

1

103

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Severna Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>Round Bay</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>FREDERICA SANDROCK ALBRECHT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 31, 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Sept. 22, 1859</u>	
9. AGE last birthday <u>96</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>- Roessler</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. H. M. Sandrock - Severna Park, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A) <u>Emilia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis generalized</u>				<u>3 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Senility</u>				<u>3 yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 10, 1956 to Jan. 31, 1956, that I last saw the deceased alive on Jan. 30, 1956, and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Kimberly Martin</u>				ADDRESS (Street, city, town, state) <u>Gringold's Md.</u>		DATE SIGNED <u>1-31-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Linden Park Cem.</u>		LOCATION (City, town, or county) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John G. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. ...</u>		ADDRESS <u>... Balt.</u>	
DATE <u>Feb. 1, 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

103

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

SEX

MARRIAGE

EDUCATION

INDUSTRY

BUREAU V. S.

FEB 2 1966

RECEIVED

RECEIVED

THIS CERTIFICATE IS TO BE FILED IN THE BUREAU OF VITAL RECORDS, DEPARTMENT OF HEALTH, BUREAU OF VITAL RECORDS, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

00104
27

Reg. Dist. No.

Item 12, See: Birth Cert.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Penna</u>		COUNTY <u>Berks</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Fort George G Meade, Md</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reading</u>		STREET ADDRESS (If rural give location) <u>RD #2, Box 539</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fort George G Meade, Md</u>							
3. NAME OF DECEASED (Type or Print) <u>INFANT BOY (JOHN D.) ALTHOUSE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 13 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>-</u>	8. DATE OF BIRTH <u>13 January 1956</u>	9. AGE last birthday <u>-</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min. <u>7 26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Fort George G Meade, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Althouse</u>				14. MOTHER'S MAIDEN NAME <u>Meng (Mother) Theresa Ann Meng</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>-</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
763.5 IMMEDIATE CAUSE (A) <u>Prematurity - Atelectasis, congenital</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs 26 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pneumonia, primary, atypical.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>-</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from, 19....., to, 19....., that I last saw the deceased alive on, 19....., and that death occurred at, M., from the causes and on the date stated above.							
SIGNATURE <u>Murray Mantol</u>		DATE THEREOF <u>16 Jan 56</u>		NAME OF CEMETERY OR CREMATORY <u>Germantown Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easport, Penna</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>WILLIAM L. SAYLOR, 1st Lt, MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>-</u>		ADDRESS <u>-</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

2150221343

CERTIFICATE OF DEATH

158

11111
11

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Usual residence		8. Cause of death		9. Manner of death	
10. Physician		11. Certifying physician		12. Signature	
13. Date		14. Signature		15. Signature	
16. Signature		17. Signature		18. Signature	
19. Signature		20. Signature		21. Signature	
22. Signature		23. Signature		24. Signature	
25. Signature		26. Signature		27. Signature	
28. Signature		29. Signature		30. Signature	
31. Signature		32. Signature		33. Signature	
34. Signature		35. Signature		36. Signature	
37. Signature		38. Signature		39. Signature	
40. Signature		41. Signature		42. Signature	
43. Signature		44. Signature		45. Signature	
46. Signature		47. Signature		48. Signature	
49. Signature		50. Signature		51. Signature	
52. Signature		53. Signature		54. Signature	
55. Signature		56. Signature		57. Signature	
58. Signature		59. Signature		60. Signature	
61. Signature		62. Signature		63. Signature	
64. Signature		65. Signature		66. Signature	
67. Signature		68. Signature		69. Signature	
70. Signature		71. Signature		72. Signature	
73. Signature		74. Signature		75. Signature	
76. Signature		77. Signature		78. Signature	
79. Signature		80. Signature		81. Signature	
82. Signature		83. Signature		84. Signature	
85. Signature		86. Signature		87. Signature	
88. Signature		89. Signature		90. Signature	
91. Signature		92. Signature		93. Signature	
94. Signature		95. Signature		96. Signature	
97. Signature		98. Signature		99. Signature	
100. Signature		101. Signature		102. Signature	

BUREAU V. E.

JAN 17 1956

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01278

Reg. Dist. No.

137

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (In this place) <u>5 mos. 10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>647 W. Fayette Street</u>			
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Bailey</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>28</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/22/07</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertensive Nephritis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION -----		19b. MAJOR FINDINGS OF OPERATION -----				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) -----		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) -----			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) -----		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> et work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR? -----			
22. I hereby certify that I attended the deceased from <u>8/18</u> , 19 <u>55</u> , to <u>1/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/28</u> , 19 <u>56</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Mildegard H. Reissmann</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>1/28/56</u>	
23. BURIAL CREATION <u>Green St</u>		DATE THEREOF <u>2/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>COFM MED SCHOOL</u>		LOCATION (City, town, or county) (State) <u>GREEN ST</u>	
24. REC'D BY REGISTRAR <u>DATE FEB 15 1956</u>		REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D. Appel</u> ADDRESS <u>BRGS 1800 E. LOMBARD</u>			

CERTIFICATE OF DEATH

187

BUREAU V. S.

FEB 16 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

00105

Reg. Dist. No. 21

104

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Annapolis, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>71 Sellers Rd</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Baby Boy BARBER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 1 19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Newborn</u>	8. DATE OF BIRTH <u>December 31, 1955</u>		9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
							<u>3 28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME <u>Horace M BARBER</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hellen WATKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>USNH Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Immaturity #776</u>						<u>3hrs 28 min</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 31, 19 55</u> , to <u>Jan 1, 19 56</u> , that I last saw the deceased alive on <u>Jan 1, 19 56</u> , and that death occurred at <u>1:25a</u> A.M. , from the causes and on the date stated above.							
SIGNATURE <u>J. T. Egan Jr</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>Commander MC USN M.D. U.S. Naval Hospital, Annapolis, Md. Jan. 3, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/3/56</u>		<u>NAVAL CEMETERY</u>		<u>Annapolis Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan. 3, 1956</u>		<u>[Signature]</u>		<u>John M. [Signature]</u>		<u>Annapolis, Md.</u>	

CERTIFICATE OF DEATH

BUREAU V. 8

JAN 6 1956

RECEIVED

138

CERTIFICATE OF DEATH

Reg. Dist. No. 24

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Round Bay</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Round Bay</u>	
OR TOWN <u>Round Bay</u>		LENGTH OF STAY (in this place)		OR TOWN <u>Round Bay</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Hiram</u> (Middle) <u>(n)</u> (Last) <u>Bell</u>				<u>Jan. 22</u> 19 <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 22, 1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager Concrete Pipe</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete Pipe</u>	11. BIRTHPLACE (State or foreign country) <u>Florida</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William Bell</u>				14. MOTHER'S MAIDEN NAME <u>Jenny Howe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT'S ADDRESS <u>Mrs. Alice C. Bell</u> # (2)			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
423.1 IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic Cardio-Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>JAN</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JAN 22</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Francis I. Codd</u> M.D.		ADDRESS (Street, city, town, state) <u>Box 289 SEVERNA PARK MD</u>		DATE SIGNED <u>1/23/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-26-56</u>		NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		LOCATION (City, town, or county) (State) <u>Greensboro, N.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. Dealba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Sm Annapolis, Md.</u>	
DATE <u>Jan 25, 1956</u>							

11-1-1956

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

REGISTRATION NO.

DATE OF DEATH

PLACE OF DEATH

SEX
AGE

BUREAU V. 21

JAN 27 1956

RECEIVED

SHORTCUTS

RECEIVED

139

CERTIFICATE OF DEATH

00107

Reg. Dist. No. 20

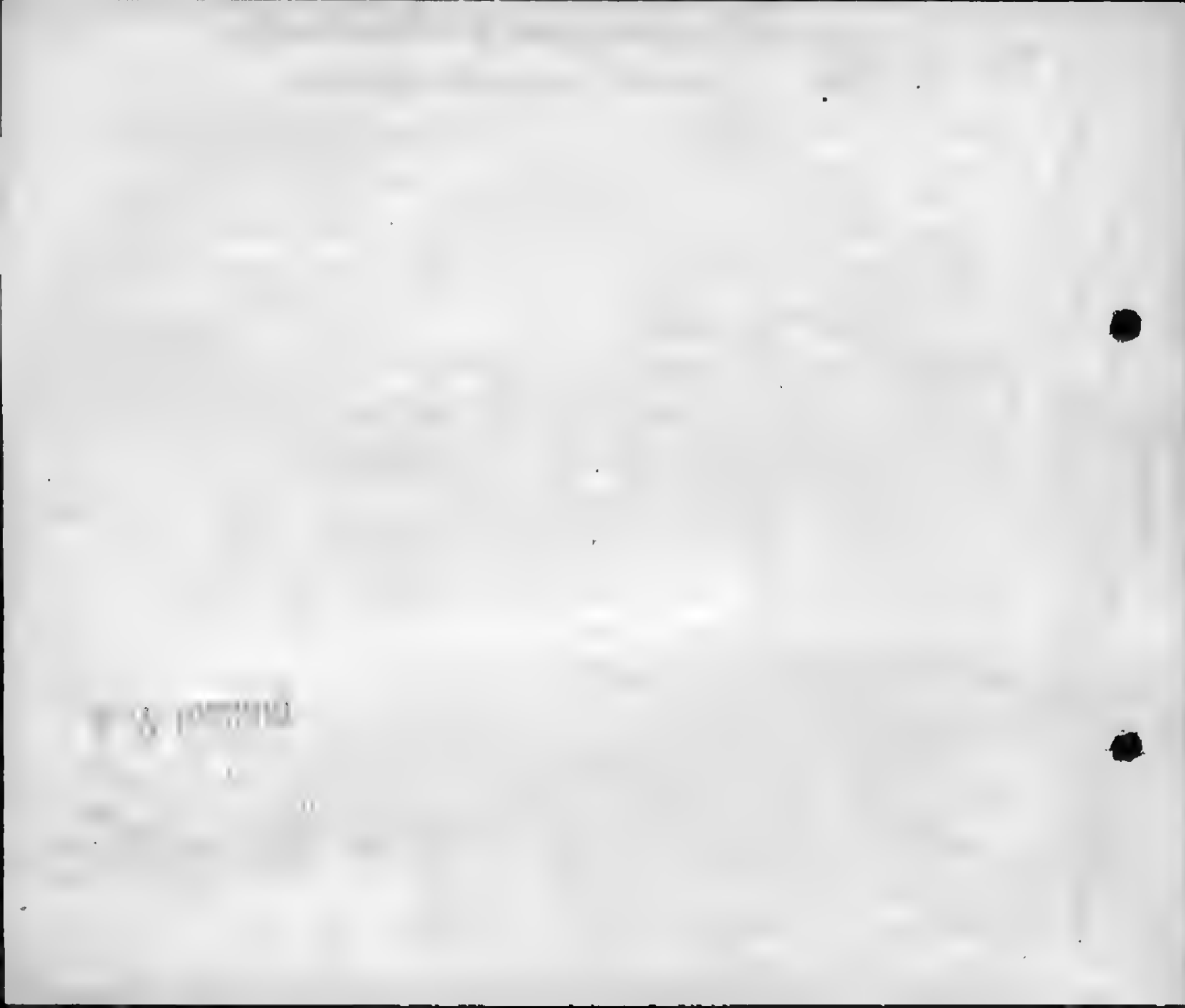
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>2 3 02</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>11</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Mayo</u>		<u>all life</u>		TOWN <u>Mayo</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Brenda</u> (Middle) <u>Lee</u> (Last) <u>Boehm</u>				(Month) <u>1-</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Sept. 21, 1953</u>	9. AGE last birthday <u>3</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months <u>3</u>	Days <u>28</u>	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kenneth Boehm</u>				14. MOTHER'S MAIDEN NAME <u>Hazel Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mother, Hazel Boehm, Mayo, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bacterial pneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>La grippe</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>not treated by any doctor</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>not stated</u> , 19... to... 19... that I last saw the deceased alive on <u>September 19</u> , 19... and that death occurred at <u>6:00</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilson (M.D.)</u>				ADDRESS (Street, city, town, state) <u>Lattimer, Md.</u>		DATE SIGNED <u>1/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-19-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hope Chapel</u>		LOCATION (City, town, or county) (State) <u>Edgewater, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan 25th</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>108 Wash. St. Annapolis, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. Also this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



00108

140

CERTIFICATE OF DEATH

Reg. Dist. No. *22*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince Anne</i>	
CITY OR TOWN <i>Severn</i>		LENGTH OF STAY <i>18 years</i>		CITY OR TOWN <i>Severn</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Severn to Jessup Road</i>				STREET ADDRESS <i>Severn to Jessup Road</i>			
3. NAME OF DECEASED (Type or Print) <i>Fanny M. Marcella Boyer</i>				4. DATE OF DEATH <i>Jan 5, 1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Nov 28, 1888</i>	
9. AGE last birthday <i>67</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Delmont, Anne Arundel Co, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>							
13. FATHER'S NAME <i>George Dutner</i>				14. MOTHER'S MAIDEN NAME <i>Emily Hankins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>George E. Boyer 7306 Schiller Rd, Baltimore, Md</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>General Arterio-Sclerosis</i>				<i>+ 4 years</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 1957</i> to <i>1/5</i> , 1956, that I last saw the deceased alive on <i>1/7/56</i> , 1956, and that death occurred at <i>3:20 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Glenn B. Burman M.D.</i>				DATE SIGNED <i>1/7/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1/7/56</i>		NAME OF CEMETERY OR CREMATORY <i>Friendship C.</i>		LOCATION (City, town, or county) <i>21st St & E. 14th</i>	
24. REC'D BY REGISTRAR <i>Chas. Taylor</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. Wright</i>		ADDRESS <i>Glenn B. Burman M.D.</i>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



141

00109

+
(#6)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 75

1. PLACE OF DEATH:

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN ARUNDEL PARK

LENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)

OR TOWN Baltimore

STREET
ADDRESS

(If rural, give location)

3216 Foster Avenue

3. NAME OF
DECEASED:
(Type or Print)

(First)

ANNA

(Middle)

ELIZABETH

(Last)

BRANDT

4. DATE
OF
DEATH

(Month)

1

(Day)

29

(Year)

19 56

5. SEX:

Female

6. COLOR OR
RACE:

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,

(Specify):

Married Jan. 30, 1895

8. DATE OF BIRTH:

9. AGE last birthday:

60 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):

Cook

10b. KIND OF BUSINESS OR
INDUSTRY:

Bon secours Hosp.

11. BIRTHPLACE (State or foreign country):

Austria

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

Samuel Emre

14. MOTHER'S MAIDEN NAME:

Anna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Miss Mary Brandt 3216 Foster Ave. #24

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

116.6

Immediate cause

(a) Carbon Monoxide Poisoning

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b) Extensive 3rd Degree Burns of Body

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN
ONSET AND DEATH21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY Public Hall

21c. (City or town)

(County)

(State)

Arundel Park

Anne Arundel

Md.

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY 1 29 56 5P.M.21e. INJURY OCCURRED
While at Not while
work ☐ at work ☒

21f. HOW DID INJURY OCCUR?

Conflagration of Public Hall

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

R. F. Fisher MD

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

M.D.

ASSISTANT MEDICAL EXAM.

DATE SIGNED

1/31/56

23. BURIAL, CREMATION,
REMOVAL (Specify):

BURIAL

DATE THEREOF

2-2-56 SACRED HEART CEM.

LOCATION (City, town, or county)

7401 GERMAN HILL RD, MD.

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

9015 CONKLING ST. ADDRESS

2-1-56

J. W. Hedrick

Charles S. Geller

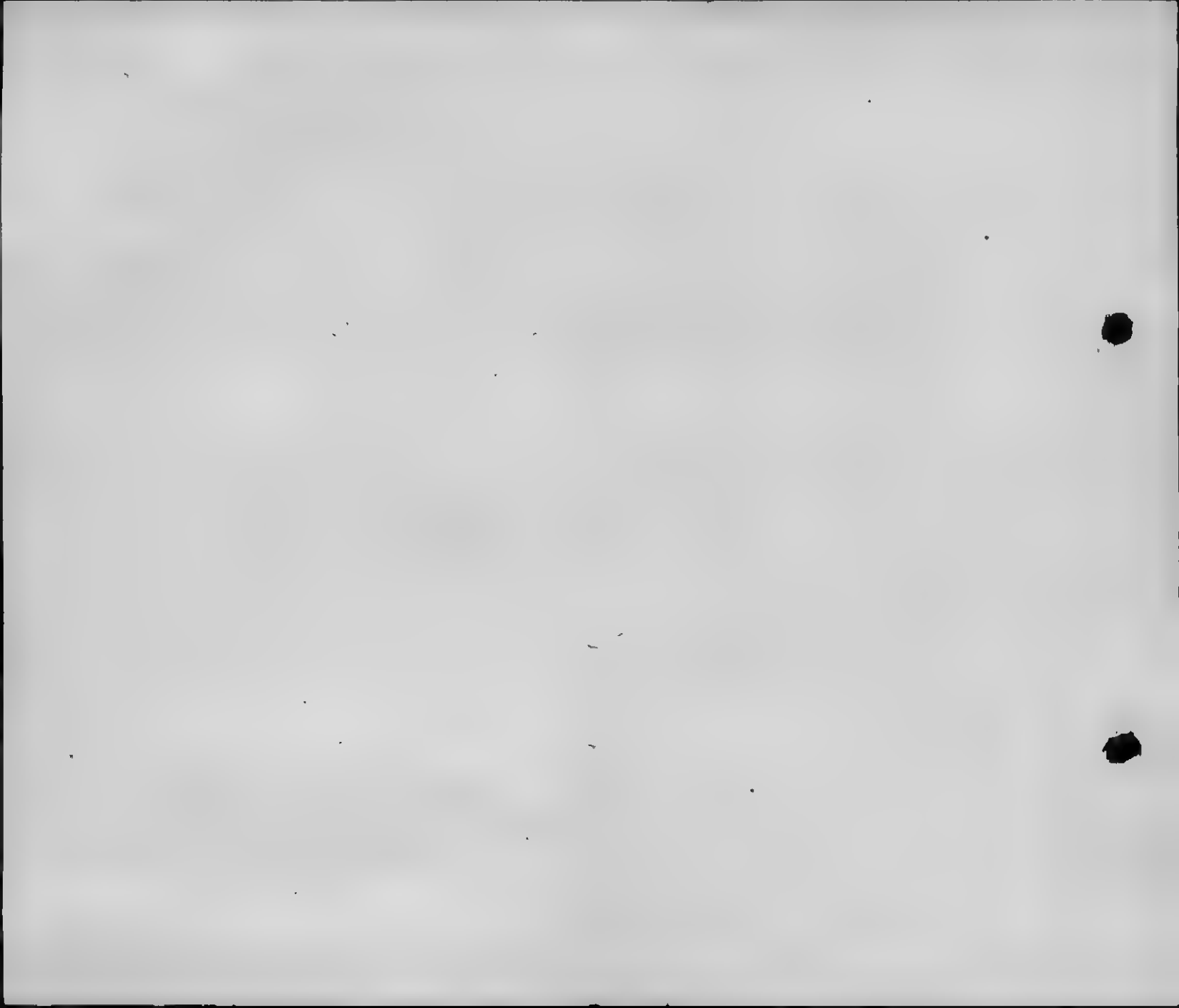
BALTO, MD.

Dance

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



142

CERTIFICATE OF DEATH

Item 8, File 191 1-10-56 et

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE Maryland		COUNTY Frederick			
CITY (If outside corporate limits, write RURAL and give nearest town) Crownsville		LENGTH OF STAY (in this place) 38 days		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) 452 W. Patrick Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Paul		(Middle) F.		(Last) Brooks		(Month) 1 (Day) 1 (Year) 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH March 2, 1927 ???		9. AGE last birthday 27 yrs.		IF UNDER 1 YEAR Months — Days —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph E. Brooks				14. MOTHER'S MAIDEN NAME Bessie Alma Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Bronchopneumonia, Confluent right side						Unknown	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/23/55 , 19 56 , to 1/1 , 19 56 , that I last saw the deceased alive on 12/30 , 19 55 , and that death occurred at 6:10 A.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>		DATE THEREOF 1/6/55		NAME OF CEMETERY OR CREMATORY Colored Cemetery		LOCATION (City, town, or county) (State) Weverton, Washington Co.	
23. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify)		DATE THEREOF 1/6/55		NAME OF CEMETERY OR CREMATORY Colored Cemetery		LOCATION (City, town, or county) (State) Weverton, Washington Co.	
24. REC'D BY REGISTRAR JAN 5 1956		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS Crownsville, Md.	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 70M

BUREAU V. S.

JAN 5 1955

RECEIVED

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third, copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00111

143

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH <i>Paradena.</i>		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Paradena.</i>	<i>8 1/2 years</i>	TOWN <i>Paradena -</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>Anna</i> (First) <i>Burggraf -</i> (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <i>Jan. 26 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Feb. 10, 1889</i>
9. AGE last birthday <i>66</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Examiner -</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>Charles Burggraf</i>		14. MOTHER'S MAIDEN NAME <i>Anna A. Wagner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-01-3449</i>	17. INFORMANT & ADDRESS <i>Mrs Harry Davis, Pasadena Md</i>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			<i>5 years.</i>
IMMEDIATE CAUSE (A) <i>Coronary Vascular Disease</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 15, 1956</i> , to <i>Jan 26, 1956</i> , that I last saw the deceased alive on <i>Jan 15, 1956</i> , and that death occurred at <i>7:10 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>James S. Billingslee</i>		ADDRESS (Street, city, town, state) <i>108 Central Ave, Glen Burnie Md</i>	
DATE THEREOF <i>Jan 30, 1956</i>		DATE SIGNED <i>Jan 26, 1956</i>	
NAME OF CEMETERY OR CREMATORY <i>London Park Bath. Md</i>		LOCATION (City, town, or county) (State) <i>Batho Md</i>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <i>L. J. Dellbax</i>		ADDRESS <i>17th</i>	
DATE <i>Jan. 27, 1956</i>			



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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>A. A. Co</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>A. A. Co</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>				TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>237 Hanover St</i>				STREET ADDRESS (If rural give location) <i>237 Hanover St</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Emma</i> (Middle) <i>Butler</i> (Last)				(Month) <i>1</i> (Day) <i>2</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>2-2-1885</i>	9. AGE last birthday <i>70</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John Hughes</i>				14. MOTHER'S MAIDEN NAME <i>Emma Hughes</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT & ADDRESS <i>Mrs. Elizabeth Adams - Annapolis Md</i>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Intermittent heart disease with</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Complete failure</i>				7 DAYS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/11</i> , 19 <i>55</i> , to <i>1/12</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>1/12</i> , 19 <i>55</i> , and that death occurred at <i>7:19</i> M., from the causes and on the date stated above.							
SIGNATURE <i>Edward Barker</i>		ADDRESS (Street, city, town, state) <i>M.D. 4th St. Baltimore Annapolis</i>		DATE SIGNED <i>1/13/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-5-56</i>		NAME OF CEMETERY OR CREMATORY <i>St Ann's</i>		LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
24. REC'D BY REGISTRAR <i>Jan 5, 1956</i>		REGISTRAR'S SIGNATURE <i>J. J. Daniel</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II</i>		ADDRESS <i>Annapolis</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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11/1/54

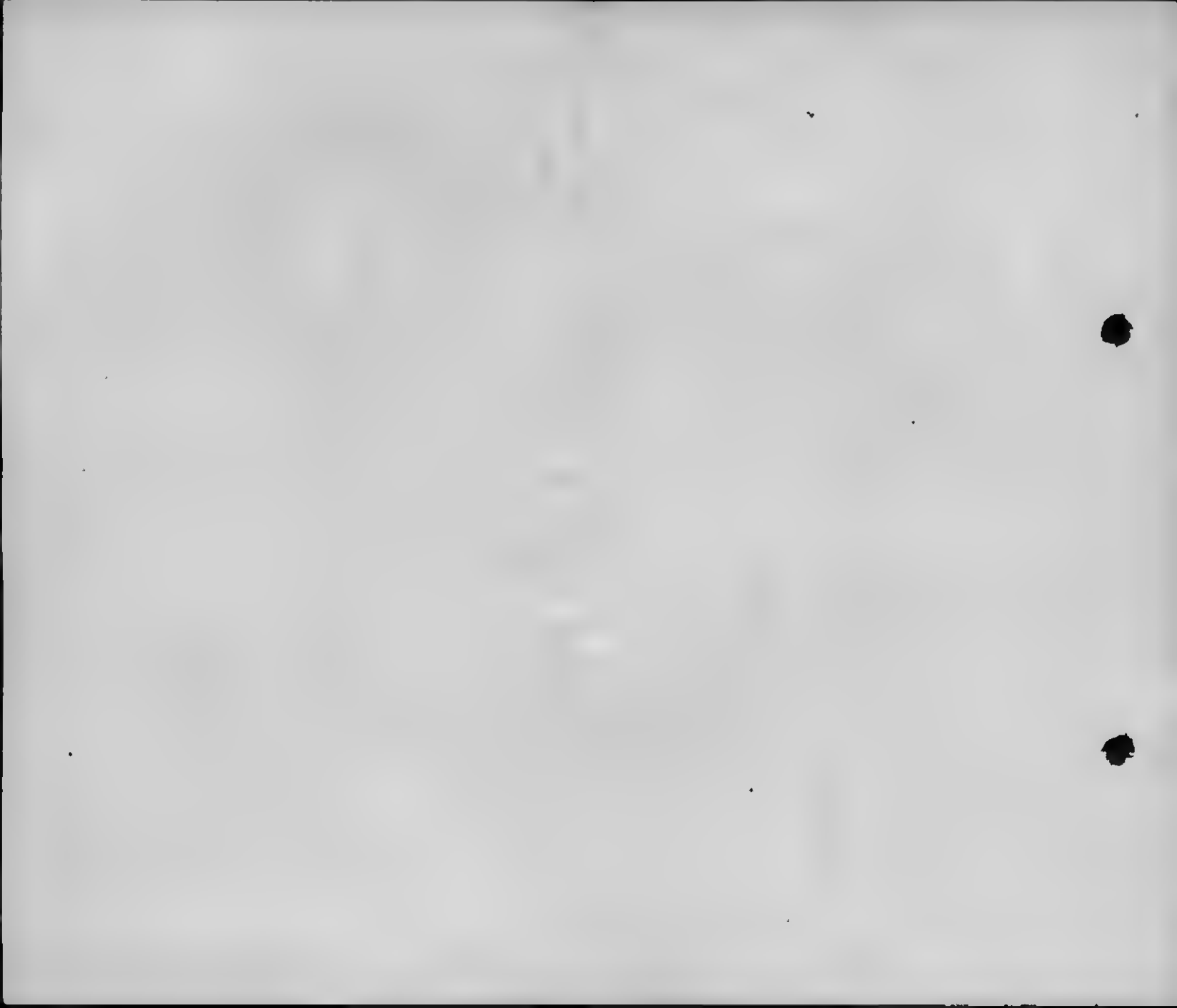
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 75

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Brooklyn Park		LENGTH OF STAY (in this place) 1 day		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Arundel Park 4901 Belle Grove Road				STREET ADDRESS (If rural, give location) 900 Pontiac Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) STELLA Agnes CAVANAUGH		4. DATE OF DEATH (Month) (Day) (Year) 1 29 19 56					
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: August 26, 1911	9. AGE last birthday: 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Clerk		10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME: John J. Neff				14. MOTHER'S MAIDEN NAME: Mary Blanche Giles Neff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 216-32-1512		17. INFORMANT & ADDRESS: Mrs. Edward Nicoli 914 Stoll St. Balto. 25, M.			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) Carbon Monoxide Poisoning					
DUE TO					
Antecedent cause(s) (b) Extensive 3rd Degree Burns of Body					
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Public Hall		21c. (City or town) (County) (State) Arundel Park Anne Arundel Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 1 29 56 5P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Conflagration of Public Hall	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		M. D.		DATE SIGNED 1/31/56	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Feb. 3, 1956		NAME OF CEMETERY OR CREMATORY New Cathedral	
LOCATION (City, town, or county) (State) Frederick Road, Balto. Md.		24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy. Balto. 25			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

00114

145

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Wm. Annapolis</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Upper Marlboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 1 rock</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lawrence</u> (Middle) <u>Chaney</u> (Last) <u>Chaney</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 12</u> 1956	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May, 14</u> 1886
9. AGE last birthday <u>69</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>A. A. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Chaney</u>		14. MOTHER'S MAIDEN NAME <u>Emma Lanham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>215-30-2671</u>	
17. INFORMANT <u>Mrs Helen Chaney, Upper Marlboro, Md</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u>		<u>Sudden</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <u>Dr. Paul H. Paulsen, M.D.</u>		DATE SIGNED <u>1/12/56</u>	
23. BURIAL, CREMATION, REBURY (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan. 16th 1956</u>	<u>Druid Ridge Cemetery</u>	<u>Pikesville, Balto Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>January 14 1956</u>	<u>R.W.</u>	<u>4510 Liberty Heights Ave.</u>	



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CERTIFICATE OF DEATH

Reg. Dist. No. 23

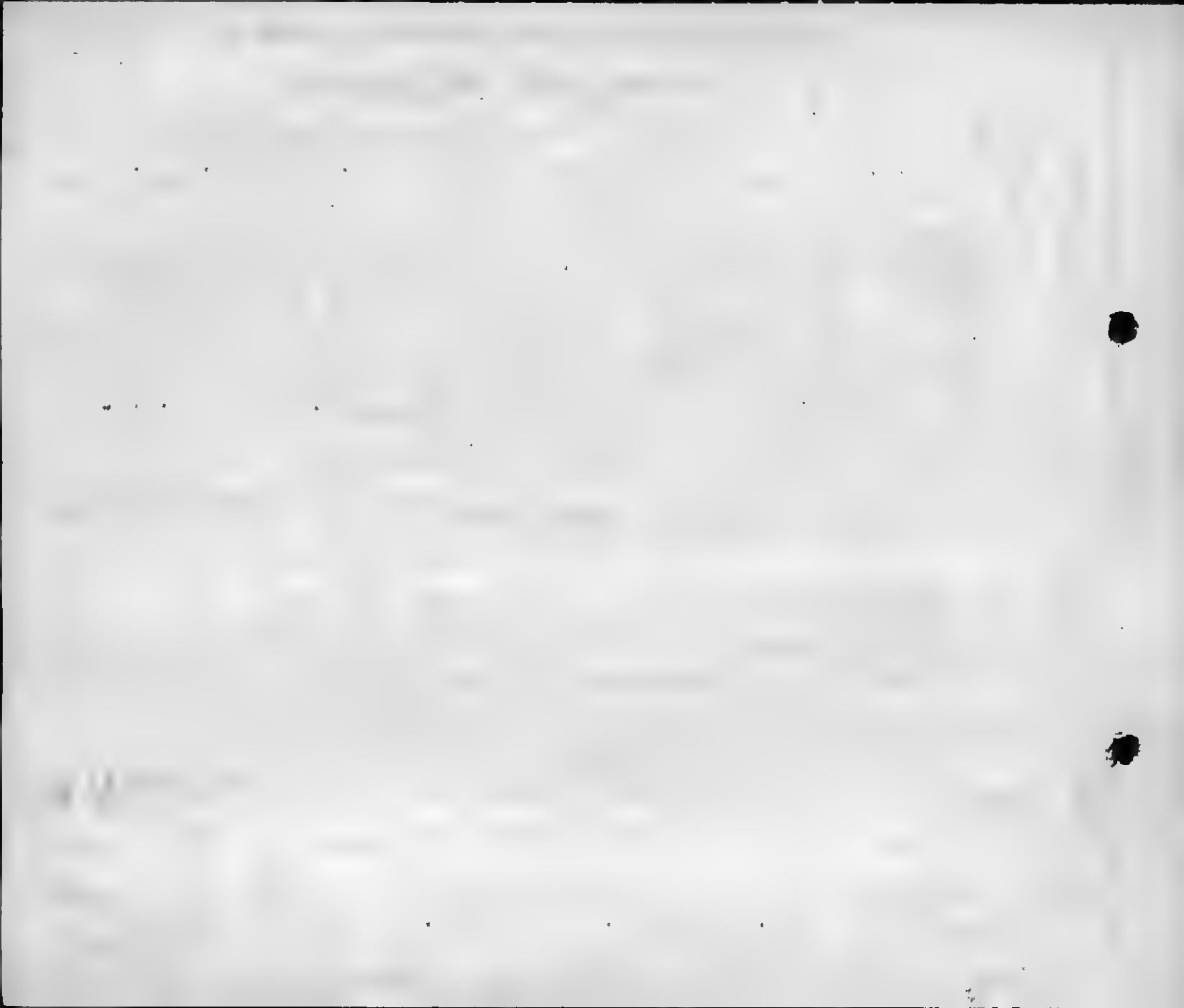
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY A.A.CO.		MARYLAND		STATE Md.		COUNTY A.A.CO.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Linthicum		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Linthicum			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Nursery & Central Ave.				STREET ADDRESS (if rural give location) Nursery & Central Ave.			
3. NAME OF DECEASED (Type or Print) ANNIE H. COATES				4. DATE OF DEATH (Month) (Day) (Year) JANUARY 11 1956			
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WID.	8. DATE OF BIRTH Jan. 15, 1889	9. AGE last birthday 66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Henrson				14. MOTHER'S MAIDEN NAME Annie ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Sadie Jones Nursery & Central		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) CORONARY THROMBOSIS				INTERVAL BETWEEN ONSET AND DEATH 36 HRS.			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 10, 1956, to Jan 11, 1956, that I last saw the deceased alive on Jan 11, 1956, and that death occurred at 11:05 P.M. from the causes and on the date stated above.							
SIGNATURE S. Miller Linthicum				ADDRESS (Street, city, town, state) Linthicum Hpts Rd.		DATE SIGNED 1/11/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 15, 1956		NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		LOCATION (City, town, or county) Cedar Hill Md.	
24. REC'D BY REGISTRAR DATE Jan. 16, 1956		REGISTRAR'S SIGNATURE Dr. Caldwell Woodruff		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams		ADDRESS 322 N. Schroeder St.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M



INSTRUCTIONS

1

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

147

CERTIFICATE OF DEATH

00116

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>2. D.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>D.C.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Tracy's Landing</u>		<u>all life</u>		TOWN <u>Tracy's Landing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>James</u> <u>Coates</u>				<u>Jan 21 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>negro</u>	<u>single</u>	<u>Sept. 10, 1906</u>	<u>4</u> yrs.	<u>4</u> Months <u>11</u> Days	<u>11</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Freeman's Washington D.C.</u>		<u>U.S.C.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Allen Coates</u>				<u>Alveta Sharps</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Father James Coates Tracy's Landing</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<u>Suffocation - due to</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>vomiting & cold.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>not at all</u> to <u>not at all</u>, 19<u>56</u>, that I last saw the deceased alive on <u>not at all</u>, 19<u>56</u>, and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Emily H. Wilson, M.D., Acting Coroner</u>				<u>Laurel, Md</u>		<u>1-21-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>1-22-56</u>		<u>Mt Hope</u>		<u>Boulderland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1/24/56</u>		<u>Elsie W. Phillips</u>		<u>P. E. Jewell, P. H. Frederick & Co</u>			

1000

1000

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00117

CERTIFICATE OF DEATH

Reg. Dist. No. 21

106

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>An. Co.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>An. Co.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>24 College Ave.</u>				STREET ADDRESS (If rural give location) <u>94 College Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>Rodriguez</u> (First) (Middle) (Last) <u>Coates</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1 12 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>10-1-55</u>	9. AGE last birthday yrs. <u>4</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, md U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Claude Coates</u>				14. MOTHER'S MAIDEN NAME <u>Betty Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>72</u>		17. INFORMANT & ADDRESS <u>Betty Jones - Annapolis</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Aspiration - Vomitus.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>None</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION <u></u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, or injury street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>Jan 12</u> , 19 <u>56</u> , to <u>Jan 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>56</u> , and that death occurred at <u>8</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Frank Hault</u>				ADDRESS (Street, city, town, state) <u>Annapolis Md</u>		DATE SIGNED <u>1-13-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		LOCATION (City, town, or county) (State) <u>Annapolis, md</u>	
24. REC'D BY REGISTRAR <u>ff - O. Daniel</u>		REGISTRAR'S SIGNATURE <u>ff - O. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II</u>		ADDRESS <u>Anna. md</u>	
DATE <u>1-16-1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

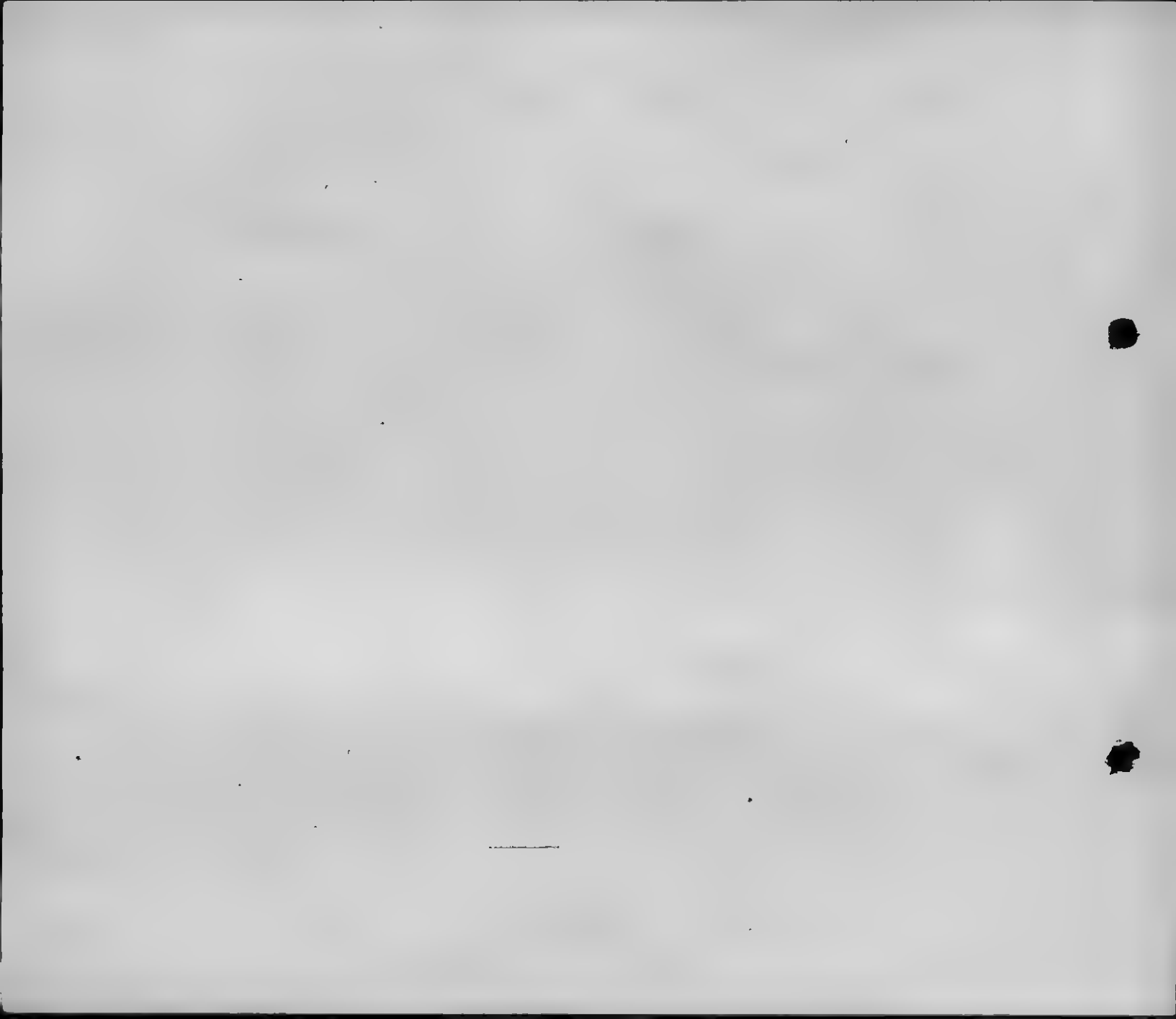
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED
AN 17 1956
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

148				#5) MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		001118 Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 25							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Brooklyn Park</u>		<u>1 day</u>		TOWN <u>Baltimore Suburban</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>4901 Belle Grove Road</u>		STREET ADDRESS (If rural, give location)			
				<u>19 Seward Avenue</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<u>FRANCES</u>		<u>J</u>		<u>COOKE</u>		<u>1 29 19 56</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>married</u>		<u>December 29, 1906</u>	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>49 yrs.</u>		<u>Housewife</u>		<u>Baltimore, Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Leon J. Obzut</u>				<u>Frances J.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>No</u>						<u>Mr. Robert J. Cooke 19 Seward Ave. Balto 25</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Carbon Monoxide Poisoning</u>							
DUE TO							
Antecedent cause(s) (b) <u>Extensive 3rd Degree Burns of Body</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
		<u>Public Hall</u>		<u>Arundel Park Anne Arundel Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>1 29 56 5P.M.</u>				<u>Conflagration of Public Hall</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>R. J. Fisher</u>		<u>Feb. 2, 1956</u>		<u>Holy Cross Cemetery</u>		<u>Ritchie Hwy. A. A. Co., Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2-1-56</u>		<u>Geo. J. Gonce</u>		<u>George J. Gonce</u>		<u>4001 Ritchie Hwy. Balto 25</u>	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

149

CERTIFICATE OF DEATH

0011928

Reg. Dist. No.

Item 7, Film G191 1-23-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crownsville</u>		LENGTH OF STAY (In this place) <u>4 yrs. 2 mos. 3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gambrills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>None given</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Olney</u> <u>Creek</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>16</u> <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec 1891?</u>	9. AGE last birthday <u>65?</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Charles Creek</u>				14. MOTHER'S MAIDEN NAME <u>Orsola Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac failure - following myocardial infarction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hemiparesis on it - old CVA</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/13/51</u> , 19 <u>51</u> , to <u>1/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/16</u> , 19 <u>56</u> and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict</u>		M. D. <u>RL. Benedict, M. D.</u>		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>1/16/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>1/22/55</u>		DATE THEREOF <u>1/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Taber Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chesterfield Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Jan. 19, 1956</u>		REGISTRAR'S SIGNATURE <u>R. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Amiel A. Johnson</u>		ADDRESS <u>Amiel A. Johnson</u>	

BUREAU V. S.

JUN

1911

150
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00120
Reg. Dist.

No. 24

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Glen Burnie</u> TOWN <u>Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 301</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Virginia</u> COUNTY CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Falls Church</u> STREET ADDRESS (If rural, give location) <u>532 Knollwood Drive, Apt. 301</u>			
3. NAME OF DECEASED: (Type or Print) <u>Eugene William</u> (First) <u>Daacke</u> (Middle) (Last)			4. DATE OF DEATH <u>January 18th</u> , 19 <u>56</u> (Month) (Day) (Year)				
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>			
8. DATE OF BIRTH: <u>Sept. 23, 1911</u>		9. AGE last birthday: <u>44</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Truck Driver</u>			10b. KIND OF BUSINESS OR INDUSTRY:				
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: <u>William Henry Daacke</u>			14. MOTHER'S MAIDEN NAME: <u>Mauda Bessie Garner</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW 11</u>			16. SOCIAL SECURITY No.: <u>304-05-0872</u>				
17. INFORMANT & ADDRESS: <u>Credentials found in his wallet. (deceased)</u>			18. MEDICAL CERTIFICATION				

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Fracture of skull</u> DUE TO				<u>Sudden</u>	
Antecedent cause(s) (b) <u>Compound fracture of left knee</u> DUE TO				"	
(c) <u>Multiple lacerations</u>				"	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>		21. HOW DID INJURY OCCUR? <u>Head on collision with another vehicle.</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Route 301</u>)		21c. (City or town) <u>Glen Burnie</u> (County) <u>A.A. Maryland</u> (State)	
21d. TIME (Month) <u>1/18/56</u> (Day) <u>1 P.M.</u> (Year) <u>56</u> (Hour) <u>1</u> (Minute) <u>1</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Head on collision with another vehicle.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Executive L. J. DeAlba</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/18/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>Jan 19</u>		NAME OF CEMETERY OR CREMATORY <u>Indianapolis Indiana</u>	
DATE REC'D BY LOCAL REG. <u>Jan 19, 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		24. FUNERAL DIRECTOR <u>Hopling and Kirkley, Glen Burnie, Md.</u>	
ADDRESS					



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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>A. A.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	STATE <u>Md.</u>	COUNTY <u>A. A.</u>
TOWN <u>Annapolis</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. General Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>HENRY ALLAN DAWSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 - 31 - 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-20-1900</u>
9. AGE last birthday <u>56</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Builder Homes</u>	
13. BIRTHPLACE (State or foreign country) <u>Mayo Md</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. FATHER'S NAME <u>Joseph R. Dawson</u>		16. MOTHER'S MAIDEN NAME <u>Isabella New</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		18. SOCIAL SECURITY NO.	
19. IF Yes, give war or dates of service		20. INFORMANT & ADDRESS <u>Homer E Dawson</u> (2)	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Anterior Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Rheumatoid Arthritis & Erythema</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March, 1950</u> to <u>1/31/56</u> , that I last saw the deceased alive on <u>1/31/56</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Frank M. Shupley</u>		DATE SIGNED <u>2/2/56</u>	
ADDRESS (Street, city, town, state) <u>Annapolis Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THREEOF <u>2-2-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial</u>		LOCATION (City, town, or county) <u>Mayo</u>	
24. REC'D BY REGISTRAR <u>J. J. Council</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>	
DATE <u>Feb. 3, 1956</u>		ADDRESS <u>Annapolis, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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1000000000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#4

151

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00122

No. 25

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Severna Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Box 236, Manhattan Beach</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>ESTHER</u>		(Middle)		(Last) <u>DOUGHERTY</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>5-26-96</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>		9. AGE last birthday: <u>59</u> yrs.		4. DATE OF DEATH: (Month) <u>1</u> (Day) <u>29</u> (Year) <u>1956</u>	
11. BIRTHPLACE (State or foreign country): <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?		9. AGE last birthday: <u>59</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
13. FATHER'S NAME: <u>John Gaultan</u>				14. MOTHER'S MAIDEN NAME: <u>Mary McGuirk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Family - Same</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Carbon Monoxide Poisoning</u> DUE TO Antecedent cause(s) (b) <u>Extensive 3rd Degree Burns of Body</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Public Hall</u>		21c. (City or town) (County) (State): <u>Arundel Park Anne Arundel Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>1 29 56 5 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Conflagration of Public Hall</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF: <u>2-2-56</u>		NAME OF CEMETERY OR CREMATORY: <u>CATH.</u>		LOCATION (City, town, or county) (State): <u>Balto</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE REC'D BY LOCAL REG. <u>2-1-56</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>		24. FUNERAL DIRECTOR: <u>[Signature]</u> ADDRESS: <u>Towson, Md.</u>	



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CERTIFICATE OF DEATH

00123

Reg. Dist. No. 21

1. PLACE OF DEATH

COUNTY

A. A.

MARYLAND

CITY (If outside corporate limits, write RURAL or and give nearest town)

TOWN

Annapolis

LENGTH OF STAY
(In this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md

COUNTY

A. A.

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Annapolis

STREET
ADDRESS105 Spa View Ave
(If rural give location)3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

Charles

Ellinghausen

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

1 -

1

19 56

5. SEX

Male

6. COLOR OR
RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
SEPARATED

Married

8. DATE OF BIRTH

1-13-1874

9. AGE last birthday

81 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Chief Clerk City Store

10b. KIND OF BUSINESS
OR INDUSTRY

Store

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT
COUNTRY

U.S.A.

13. FATHER'S NAME

Herman Ellinghausen

14. MOTHER'S MAIDEN NAME

Elizabeth Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

Herman C. Ellinghausen (2)

17. INFORMANT & ADDRESS

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A)

DUE TO

Chr. Passive Congestion

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

Antycoagulant C. V. System

DUE TO

(C)

All symptoms

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

Smoking

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH

1 wk

4 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year)

(Hour)

21e. INJURY OCCURRED

While

at work ☐

Not while

at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/6, 1955, to 1/1, 1956, that I last saw the deceased alive on 1/1, 1956, and that death occurred at 7:30 P.M. from the causes and on the date stated above.

SIGNATURE

Mamie Klawans M.D.

ADDRESS (Street, city, town, state)

Annapolis, Md.

DATE SIGNED

1/1/56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

1-4-56

NAME OF CEMETERY OR CREMATORY

Cedar Bluff

LOCATION (City, town, or county)

Annapolis

(State)

Md

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

J. J. Danach

25. FUNERAL DIRECTOR'S SIGNATURE

John M. Styles

ADDRESS

Annapolis Md

DATE

Jan. 4, 1956

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

574.0000

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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		STATE <u>Maryland</u> COUNTY <u>A-A</u>		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place)		TOWN <u>Annapolis</u>		STREET ADDRESS (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. General Hosp.</u>				<u>23 Bunker St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Margaret Herbert Harris</u>				<u>1 6 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>6-15-1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>A. A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Rice</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>		17. INFORMANT & ADDRESS <u>Calvin Herbert Annapolis, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) _____							
ANTECEDENT CAUSE(S) DUE TO _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-6-56</u> , 19 <u>56</u> , to <u>1-6-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-6-56</u> , 19 <u>56</u> , and that death occurred at <u>1:00</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>62 Capital City Dr. Annapolis, Md.</u>		DATE SIGNED <u>1-9-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-10-56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		LOCATION (City, town, or county) (State) <u>Sunderland, Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Annapolis, Md.</u>	
DATE <u>1-16-1956</u>							

INSTRUCTIONS

TO ATTACHED INQUIRY OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly shall be detached for use as a burial transit permit.

BUREAU W. S.

JAN 17

RECEIVED

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Item 6 see Birth Cert.

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY AA	MARYLAND	STATE Md	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Annapolis	1 hr 50 min	TOWN Annapolis	
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Annapolis		STREET ADDRESS 3635 Edmondson Avenue Baltimore, Md.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Baby Boy ELSTON		January 9 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
M	White		9 January 1956
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
yrs. Months Days		U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Bernard Phillip ELSTON		Janet GOODELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)			
17. INFORMANT & ADDRESS			
USNH Records			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		1 hr 50 min	
IMMEDIATE CAUSE (A)		Prematurity #776	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST, DUE TO			
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
M. 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 1-9-1956, to 1-9-1956, that I last saw the deceased alive on 1-9-1956, and that death occurred at 11:15a.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
E.R. PHILLIPS LCDR U.S. USN		U.S. Naval Hospital, Annapolis, Md. 1-9-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		Naval Academy	
DATE THEREOF		LOCATION (City, town, or county) (State)	
1-11-56		Annapolis Md	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE		ADDRESS	
DATE Jan. 12, 1956		John W. Taylor Sons Annapolis Md	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

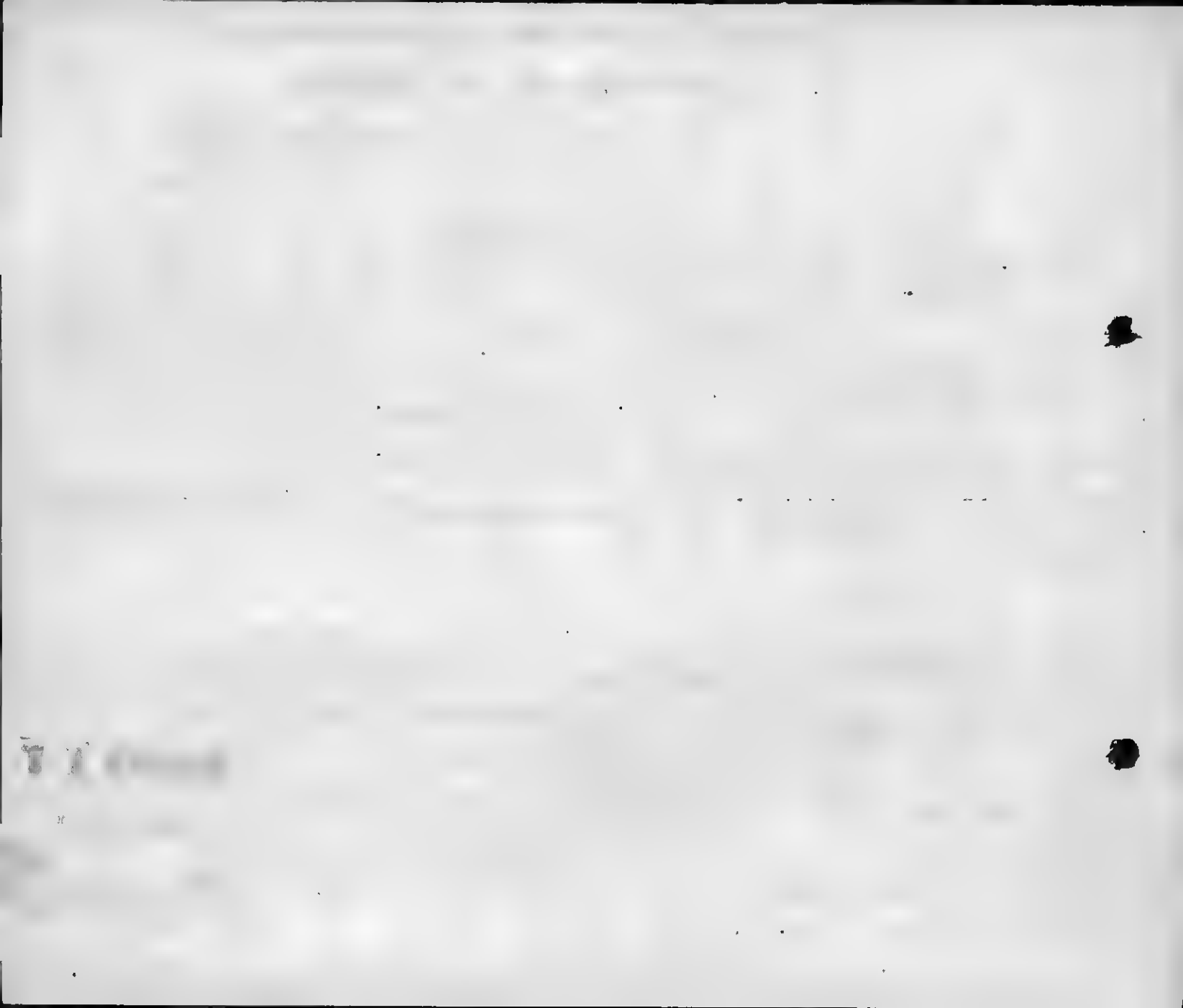
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CERTIFICATE OF DEATH

00126

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Herold Harbor			
HOSPITAL OR INSTITUTION OR STREET ADDRESS DOA Anne Arundel General Hospital				STREET ADDRESS (If rural give location) Crownsville Post Office			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) RALPH (Middle) A (Last) EVICK				(Month) JANUARY (Day) 23 (Year) 19 56			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 31, 1905	9. AGE last birthday 50 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Fire Dept.		11. BIRTHPLACE (State or foreign country) Coalton, W.Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ludwell Lee Evick				14. MOTHER'S MAIDEN NAME Nora E. Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs Adline E. Evick- wife- same as # 2			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) coronary heart disease							
ANTECEDENT CAUSE(S) DUE TO (B) arteriosclerosis of coronary vessels						6 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) complete rt bundle branch bloc							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-11, 1955, to 1-23, 1956, that I last saw the deceased alive on 1-14, 1956, and that death occurred at 11 A.M. from the causes and on the date stated above.							
SIGNATURE Earl Pooler M.D.				ADDRESS (Street, city, town, state) 45 Franklin St., Annapolis Md. 1-2557		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan 26, 1956		NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. REC'D BY REGISTRAR DATE JAN. 25, 56		REGISTRAR'S SIGNATURE J. J. Branch		25. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ANNAPOLIS, MD.			



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

00127

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL or give nearest town) <u>Ston Burnie</u>		LENGTH OF STAY (In this place) <u>2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ston Burnie</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>31 G. hester Circle</u>				STREET ADDRESS (if rural give location) <u>31 G. hester Circle</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Henry</u> (Middle) <u>Fell</u> (Last) <u>Fell</u>				(Month) <u>1</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>5/13/1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coppers Co. Baltimore</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John P. Fell</u>				14. MOTHER'S MAIDEN NAME <u>Lena Schamberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS <u>Mrs Catherine S. Higdon Circle</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>CARCINOMA of LUNG (LEFT)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u> </u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Degenerative Cardio Vascular Disease</u>							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>6/18</u> , 19 <u>55</u> , to <u>1/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>56</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above							
SIGNATURE <u>A. H. Hornstein M.D.</u>				ADDRESS (Street, city, town, state) <u>204 E Biddle St - Balt - Md.</u>			
DATE <u>1/28/56</u>				DATE SIGNED <u>1/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		LOCATION (City, town, or county) (State) <u>4430 Belair Rd</u>	
24. REC'D BY REGISTRAR <u> </u>		REGISTRAR'S SIGNATURE <u>L. J. DeLlano</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Lowan</u>		ADDRESS <u> </u>	
DATE <u>January 28-1956</u>							



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

153

CERTIFICATE OF DEATH

00128

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		STATE <u>MD</u> COUNTY <u>AA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ST MARGARETS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ST MARGARETS</u>	
TOWN <u>ST MARGARETS</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <u>FRANCES LANCE FERRERO</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-15-56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>12-7-1865</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>GENEVA N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WALTER W. LANCE</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>HER OWN INFORMATION</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Heartmic Cause</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arterio-Sclerosis</u>				<u>arterio</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic interstitial Nephritis</u>				<u>General</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 13</u> , 19 <u>56</u> , to <u>Jan 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 15</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P</u> .M., from the causes and on the date stated above.							
SIGNATURE <u>Charles Purvis</u> M.D. <u>Charmpton Md.</u>				ADDRESS (Street, city, town, state) <u>1-17-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>1-17-56</u>		NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>		LOCATION (City, town, or county) (State) <u>Pri Geo Co Md</u>	
24. REC'D BY REGISTRAR <u>Jan 18, 1956</u>		REGISTRAR'S SIGNATURE <u>John M. Taylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Sms Linnaeapolis Md</u>	

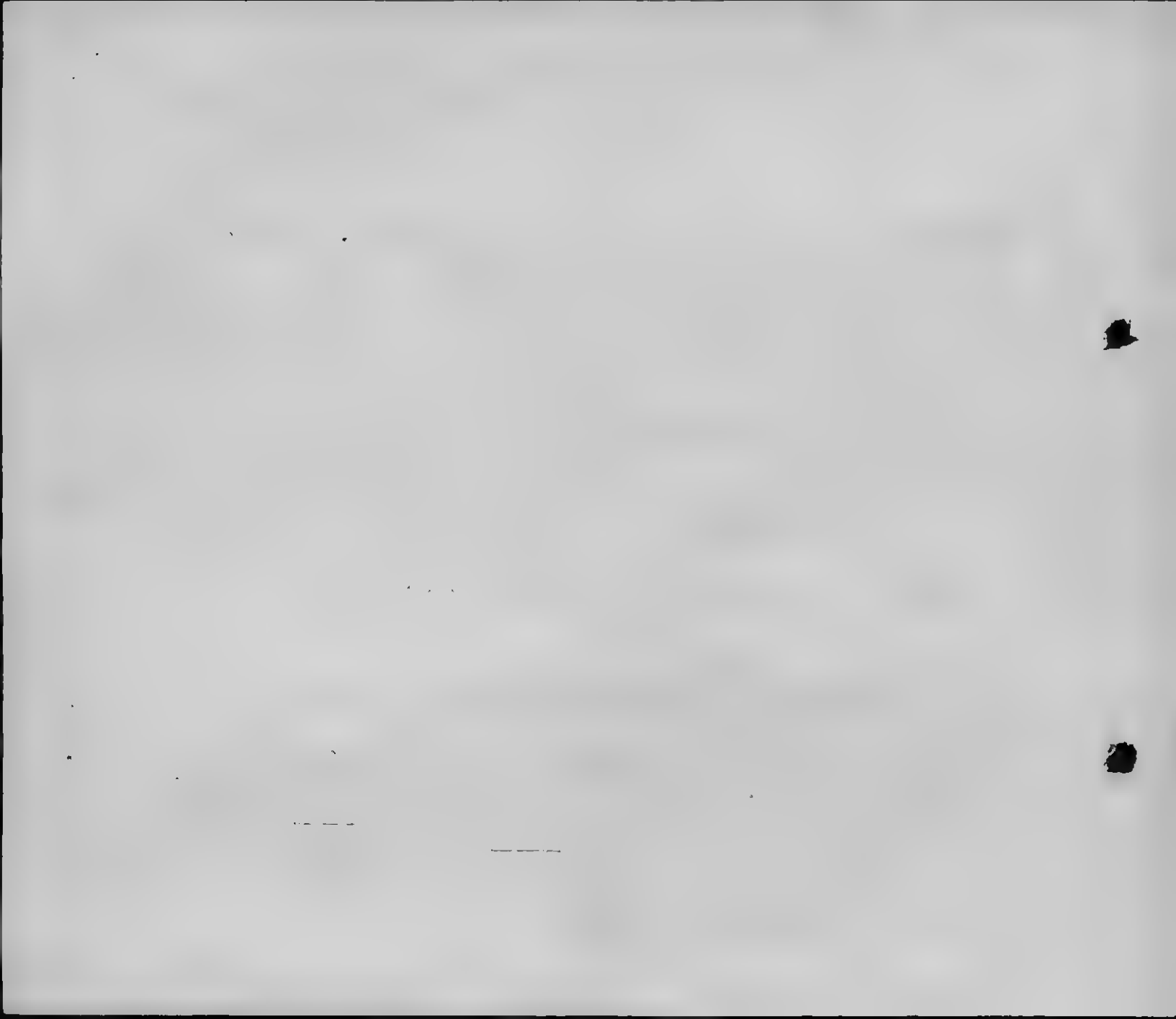
BUREAU V. S.

JAN 19 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

154				00129			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel Brooklyn</u> MARYLAND				STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Brooklyn Park</u>				CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>414 S. Washington Street</u>			
3. NAME OF DECEASED:		(First)	(Middle)	(Last)	4. DATE OF DEATH		(Month) (Day) (Year)
(Type or Print)		<u>JOSEPHINE</u>		<u>FRANCZKOWSKI</u>	<u>1</u> <u>29</u> <u>1956</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:		9. AGE last birthday: yrs. Months Days	
<u>Female</u>	<u>White</u>			<u>Sept 21/21</u>		<u>34</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME: <u>Andrew Angszek</u>			
14. MOTHER'S MAIDEN NAME: <u>Ragula</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS: <u>John Franczkowski, husband</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) ... <u>Carbon Monoxide Poisoning</u> DUE TO							
Antecedent cause(s) (b) ... <u>Extensive 3rd Degree Burns of Body</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Public Hall</u>			21c. (City or town) (County) (State) <u>Arundel Park Anne Arundel Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1</u> <u>29</u> <u>56</u> <u>5P.M.</u>			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			21f. HOW DID INJURY OCCUR? <u>Conflagration of Public Hall</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. P. Fisher</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1/31/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Feb. 2/56</u>		NAME OF CEMETERY OR CREMATORY <u>St Stanislaus</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REG. <u>2-1-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Fred W. Ozogowski</u>		ADDRESS <u>1930 Eastern</u>	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. All this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

112

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00130

Item 21 Film 6191 1-13-56

(Item 2, Film 6121 1-11-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		STATE <u>Md.</u>		COUNTY	
TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. General Hospt.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Ellen Wurt Fulton Sr.</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Sept 21-1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Builder</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward M. Fulton</u>				14. MOTHER'S MAIDEN NAME <u>Wenford Wurt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Elizabeth Reim Fulton Wife</u> ②	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Communitated intertrochanteric fr. l. femur</u>				5d			
ANTECEDENT CAUSE(S) (B) <u>Fractured bronchitis</u>				4d			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Ac - Pulmonary edema</u>				4d			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized arteriosclerosis</u>				gc -			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>Severna Park</u>		(County) <u>A.A.</u> (State) <u>Md.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12 27 55 8 P.M.</u>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall</u>			
22. I hereby certify that I attended the deceased from <u>12/27</u> , 19 <u>55</u> , to <u>1/1/</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/1/</u> , 19 <u>56</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Stucky</u>				ADDRESS (Street, city, town, state) <u>M.D. Annapolis, Md.</u>		DATE SIGNED <u>1/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-4-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cent</u>		LOCATION (City, town, or county) <u>Annapolis Md</u>	
24. REC'D BY REGISTRAR <u>John M. Saylor</u>		REGISTRAR'S SIGNATURE <u>John M. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u>		ADDRESS <u>Annapolis Md</u>	
DATE <u>Jan. 4, 1956</u>							

FOR THE

RECORD

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS A15C 1-55 11M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00131

155

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mayo</u>		<u>Lifetime</u>		TOWN <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mayo, Md.</u>				STREET ADDRESS (If rural give location) <u>Mayo</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>George</u>		(Middle) <u>Thomas</u>		(Last) <u>Gardner</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>July 8, 1886</u>	
						9. AGE last birthday <u>69</u> yrs.	
						IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>		11. BIRTHPLACE (State or foreign country) <u>Mayo, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Thomas Gardner</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>James Wesley Gardner, Mayo, Md.</u>			
		(If Yes, give war or dates of service)					
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>48 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 15, 1956</u> to <u>Jan. 15, 1956</u> , that I last saw the deceased alive on <u>Jan. 15, 1956</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above							
SIGNATURE <u>Vincent G. Gaud</u> M.D.				DATE SIGNED <u>1-15-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/18/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial</u>		LOCATION (City, town, or county) (State) <u>Mayo, Md.</u>	
24. REC'D BY REGISTRAR <u>1-20</u>		REGISTRAR'S SIGNATURE <u>Charles W. Williams</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Halshutz</u> ADDRESS <u>Galesville, Md.</u>			

STANLEY V. S.

JAN 1

1900

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00132

113

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE-ARUNDEL</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>ANNE-ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>3 days</u>		TOWN <u>Pasadena P.O. - GREEN HAVEN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ANNE-ARUNDEL-GENERAL-HOSP</u>				STREET ADDRESS (If rural give location) <u>Route-3-Box 426 4th Catherine-st.</u>			
3. NAME OF DECEASED (Type or Print) <u>SHARON GINEVAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 1 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Aug-31-1955</u>	
9. AGE last birthday <u>4</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carl-W. Ginevan</u>				14. MOTHER'S MAIDEN NAME <u>Bessie-M. Montgomery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Bessie-M. Montgomery</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>102X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 31, 1955</u> to <u>Jan 1, 1956</u> that I last saw the deceased alive on <u>Jan 1, 1956</u> and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Nail H. Lewis</u> M.D. <u>95 Cathedral St.</u> DATE SIGNED <u>1/1/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>January 1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Green Haven Cemetery</u>		LOCATION (City, town, or county) <u>Clon-Burnie Maryland</u>	
24. REC'D BY REGISTRAR <u>556</u>		REGISTRAR'S SIGNATURE <u>Don J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singletary</u>		ADDRESS <u>Green Burnie, Md.</u>	

100-100000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

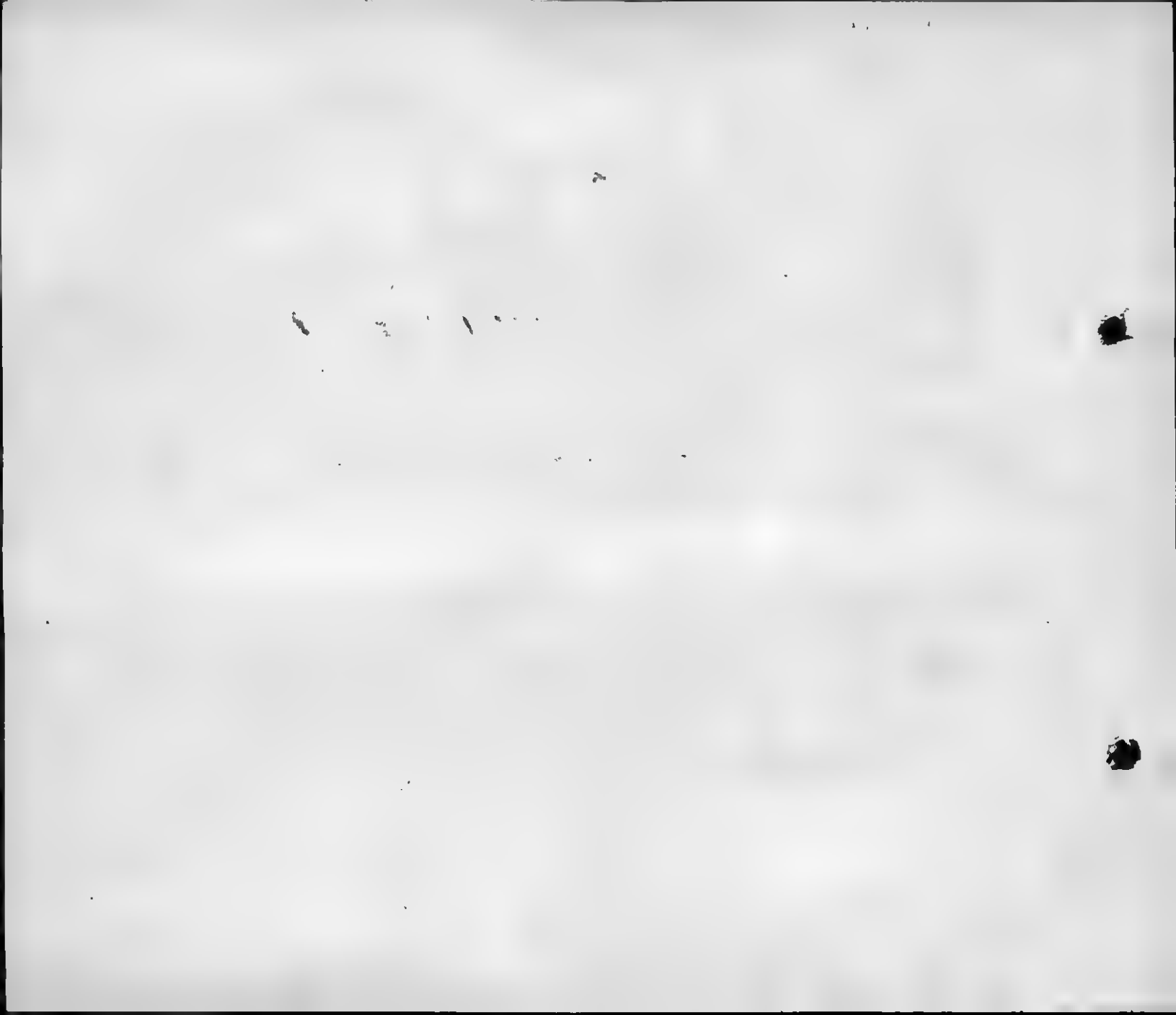
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00133

156

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hamover</u> LENGTH OF STAY (in this place) <u>70 yrs</u> TOWN <u>Hamover</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Elbridge Landing Rd</u>				STATE <u>Md</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hamover</u> OR TOWN <u>Rural</u> STREET ADDRESS (If rural give location) <u>Elbridge Landing Rd</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>George Washington Green</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan 18</u> 19 <u>56</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Oct 9, 1884</u> 71 yrs.	
9. AGE last 1. theory IF UNDER 1 YEAR Months Days Hours Min.				9. AGE last 1. theory IF UNDER 1 YEAR Months Days Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>			
11. BIRTHPLACE (State or foreign country): <u>Davidsonville Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Samuel Green</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Simmers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>216-70-8443</u>			
17. INFORMANT'S ADDRESS: <u>anderson way land</u> <u>Elyseas Shands (daughter) antebellum md</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chr Myocarditis</u>						6 mos	
ANTECEDENT CAUSE (B) DUE TO <u>cardiovascular</u>						1 yr	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>General arteriosclerosis</u>						3 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 10</u> , 19 <u>55</u> , to <u>Jan 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 18</u> , 19 <u>56</u> , and that death occurred at <u>8 20</u> M, from the causes and on the date stated above.							
SIGNATURE <u>B.B. Brumbaugh</u>		M.D. <u>Elbridge Landing Rd</u>		DATE SIGNED <u>1/18/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/21/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Saints Rest Cem.</u>		LOCATION (City, town, or county) (State) <u>Hamover Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>January 21 1956</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Miss Ruth R. Williams</u>		ADDRESS <u>9 Lehigh St</u>	



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00134

114

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A. Co.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>A. A. Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10. TOWN <u>Annapolis</u>				CITY <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10. <u>29 Johnson St.</u>				<u>29 Johnson St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Samuel</u> (First) <u>Hall</u> (Middle) (Last)				1 9 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>Male</u>	<u>Col.</u>	<u>M.</u>	<u>3-4-1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Lothian Maryland U.S.A.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Hall</u>				<u>Harriett Randall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Hattie Hall - Annapolis Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.1 IMMEDIATE CAUSE (A) <u>interior perforating gangrene of</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>the left foot</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/> P. <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 19, 1956</u> to <u>Jan 9, 1956</u> , that I last saw the deceased alive on <u>Jan 19, 1956</u> , and that death occurred at <u>10:24 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>William Klee, Jr.</u>		<u>M. D. 110 - Clarks Ave. c/o 1/10/56</u>		<u>1/10/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-17-56</u>		<u>Chews Chapel</u>		<u>Queen Anne's Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1-16, 1956</u>		<u>W. Klee, Jr.</u>		<u>William Klee, Jr.</u>		<u>Annapolis, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

JAN 17 1961

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

157

00135

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Baltimore's 50</u>	LENGTH OF STAY (in this place) <u>20</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>325-Cedar Hill Lane</u>		STREET ADDRESS (If rural, give location) <u>325 Cedar Hill Lane</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>John</u> (Middle) <u>Enoch</u> (Last) <u>Hamlen Sr.</u>		(Month) <u>Jan.</u> (Day) <u>7</u> (Year) <u>1956</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>4/12/94</u>
9. AGE last birthday: <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Police</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles G. Hamlen</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Strickman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs Virginia Baskgate (daughter)</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Coronary Occlusion</u>		<u>Sudden</u>	
(b) Antecedent cause(s) <u>None</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)	21c. (City or town) (County) (State)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Walter H. P. ...</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/2/56</u>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>1-10-56</u>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>1-10-56</u>	REGISTRAR'S SIGNATURE <u>Walter H. P. ...</u>	24. FUNERAL DIRECTOR <u>Walter H. P. ...</u> ADDRESS <u>...</u>	



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CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>D.A.</i>		MARYLAND		STATE <i>MD.</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <i>Brooklyn</i>				TOWN <i>Baltimore</i>			
HOSPITAL OR STREET ADDRESS <i>109 W. H. H. Rd.</i>				STREET ADDRESS (If rural give location) <i>109 W. H. H. Rd.</i>			
3. NAME OF DECEASED (Type or Print) <i>Stewart J. Holsinger</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>1-8-56</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M.</i>	8. DATE OF BIRTH <i>1-20-49</i>	9. AGE last birthday <i>56</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Electrician</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Daniel</i>				14. MOTHER'S MAIDEN NAME <i>Jean Thompson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not.) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Family - Same</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.1 IMMEDIATE CAUSE (A) <i>Peripheral vascular collapse</i>				<i>3 Minutes</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Pulmonary Edema</i>				<i>10 Minutes</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Acute Myocardial Infarction</i>				<i>20 minutes</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Diabetes Mellitus</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/5/56</i> , 19 <i>56</i> , to <i>1/8/56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1/5/56</i> , 19 <i>56</i> , and that death occurred at <i>5:40 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Lemard H. Flax, M.D.</i>		M.D.		ADDRESS (Street, city, town, state) <i>302 Patuxent Baltimore, Md.</i>		DATE SIGNED <i>1/9/56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		DATE THEREOF <i>1-12-56</i>		NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>		LOCATION (City, town, or county) (State) <i>Ba 110.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mrs. M. R. Whitson</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. C. Cooey</i>		ADDRESS <i>Theresa House</i>	

JAN 10 1956

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



159

CERTIFICATE OF DEATH

Reg. Dist. No.

ITEM 7 FIRM G-201, 8/28/56 BH

1. PLACE OF DEATH

COUNTY

ANNE ARUNDEL

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Millersville, Md.

LENGTH OF STAY (in this place)

unknown

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md.

COUNTY

Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Millersville,

STREET ADDRESS

(If rural give location)

none

3. NAME OF DECEASED (Type or Print)

(First)

Charles

(Middle)

Dudley

(Last)

Horde

4. DATE OF DEATH

(Month)

Jan.

(Day)

2

(Year)

19 56

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

MARRIED

8. DATE OF BIRTH

May 15, 1916

9. AGE last birthday

39 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

News paper route

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Roy Horde

14. MOTHER'S MAIDEN NAME

Alice Hatch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

yes W.W. 2

16. SOCIAL SECURITY NO.

577-09-4454

17. INFORMANT & ADDRESS

Mrs. Alice Horde
Carrolton Manor, Severna Park, Md.

18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

18. MEDICAL CERTIFICATION

CARCINOMA, colon with metastasis to LIVER

INTERVAL BETWEEN ONSET AND DEATH

8 months

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

1955

19b. MAJOR FINDINGS OF OPERATION

CARCINOMA ascending colon with metastasis to liver

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 19 55, to Jan. 19 56, that I last saw the deceased alive on Jan. 2, 19 56, and that death occurred at 3:15 P.M. from the causes and on the date stated above.

SIGNATURE

Francis J. Codd

M.D.

Box 284

ADDRESS (Street, city, town, state)

Severna Park Md

DATE SIGNED

1-2-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

burial

DATE THEREOF

1/5/56

NAME OF CEMETERY OR CREMATORY

Rock Creek Cemetery

LOCATION (City, town, or county)

Washington, D.C.

(State)

24. REC'D BY REGISTRAR.

REGISTRAR'S SIGNATURE

J. M. Joyce

25. FUNERAL DIRECTOR'S SIGNATURE

J. S. Hines Co.

ADDRESS

2501 14th St Washington, DC

DATE

1956

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

JAN 5 1

RECEIVED

115
CERTIFICATE OF DEATH

Reg. Dist. No. 21

Items 8,9 FilrG192 1-31-56 et

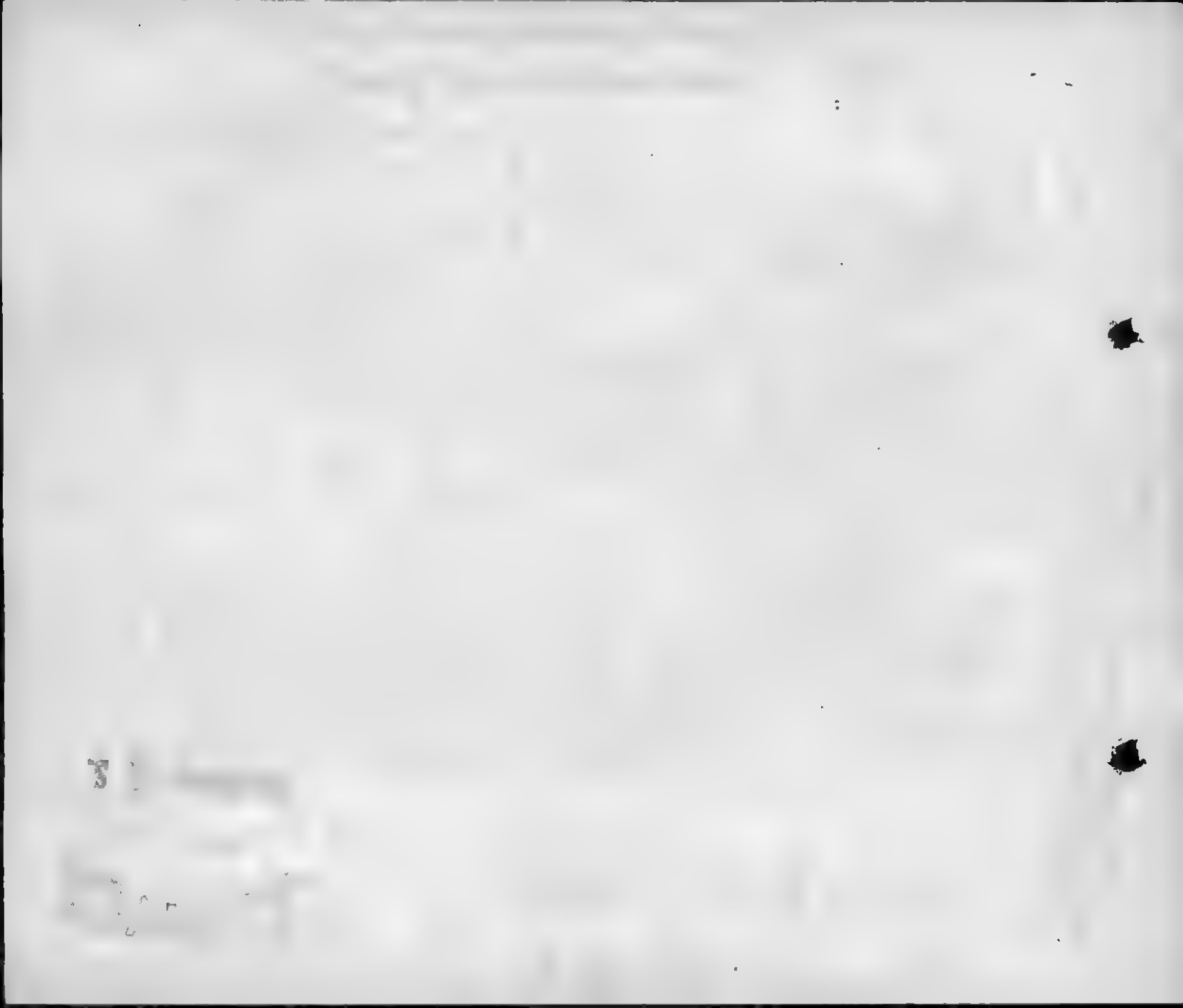
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne arundel		MARYLAND		STATE Maryland		COUNTY a.d.	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Annapolis		4 days		TOWN Jewell		AA Co Md	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne arundel General				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
James Jackson				1 - 4 - 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	C		Feb 17, 1893	71 7/8 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
FARM LABORER					Maryland		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Philip Jackson				J			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				Annie Jackson Jewell Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
3 IX IMMEDIATE CAUSE (A)				Interval between ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				hypertension, arteriosclerosis			
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 19, 1953, to Jan 4, 1956, that I last saw the deceased alive on Jan 3, 1956, and that death occurred at 6:34 A.M. from the causes and on the date stated above.							
SIGNATURE Emily H. Wilson				ADDRESS (Street, city, town, state) Baltimore, Md 1/4/56			
23. (BURIAL) CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		1-2-56		Union Chapel		AA Co Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		H. W. Ward		P. E. Sewell		P. Frederick Jones	
DATE 1-5-56							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



116

CERTIFICATE OF DEATH

Reg. Dist. No. 21

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A. Co.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>A. A. Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>32 W. Washington, St.</u>				<u>32 W. Washington, St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Florence Johnson</u>				<u>9 16 1956</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>Col</u>		<u>W.</u>		<u>8-6-1898</u>	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>57 yrs.</u>		<u>Housewife</u>		<u>Barab. Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MARDEN NAME			
<u>William Adams</u>				<u>Mary Duwall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS	
<u>No</u>				<u></u>		<u>Mary Wynn - Annapolis, Md</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>1977</u> IMMEDIATE CAUSE (A) <u>Carcinomatosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (B)							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Edema; Pulmonary Embolism</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<u></u>		<u></u>		<u></u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u></u>		<u></u>		<u></u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<u></u>		<u></u>		<u></u>			
22. I hereby certify that I attended the deceased from <u>Jan 6 1956</u> to <u>Jan 6 1956</u> , that I last saw the deceased alive on <u>Jan 6 1956</u> , and that death occurred at <u>17:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>D. H. Rickard</u>		DATE THEREOF <u>1/10/56</u>		ADDRESS (Street, city, town, state) <u>M.D. 110 - Clay St. Annapolis, Md.</u>		DATE SIGNED <u>1/10/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>Burial - H-56</u>		<u>Brewer Hill</u>		<u>Annapolis, Md</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. D. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1-16-56</u>		<u></u>		<u>William Reese, Jr.</u>		<u>Annapolis, Md</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

Item 21 Film 6192 2-2-6 at

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 28

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel	MARYLAND	STATE Md.	CITY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Crownsville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Edgemere	(If rural, give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital		STREET ADDRESS 2508 Sycamore Avenue	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
PHILLIP MARCELLOUS JONES		1 2 19 56	
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 7/11/19
9. AGE last birthday: 36 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Inmate at Hospital		11. BIRTHPLACE (State or foreign country): Sparrows Point, Maryland	
13. FATHER'S NAME: Howard Jones		14. MOTHER'S MAIDEN NAME: Marion Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: Marion Jones, 2508 Sycamore Avenue			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a)..... Crushed chest		
DUE TO		
Antecedent cause(s) (b).....		
Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c).....		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
Crownsville	Ad.	Ad.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 1/2/56 P.M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell from ramp to ground

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>William V. Jones</i>		M. D. ASSISTANT MEDICAL EXAM. 1/3/56	
23. BURIAL, CREMATION, REMOVAL (Specify): Removal	DATE THEREOF 1-6-56	NAME OF CEMETERY OR CREMATORY Mt. Calvary Ch.	LOCATION (City, town, or county) A.A. Co. Md.
DATE REC'D BY LOCAL REG. 1/4/56	REGISTRAR'S SIGNATURE A. H. Herberich	24. FUNERAL DIRECTOR Samuel W. Sullivan Jr. 1011 Bellington Ave.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15A - 5 - 53



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161

CERTIFICATE OF DEATH

Reg. Dist. No. *yr*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>AA</u>			
CITY OR TOWN <u>Odenton, Md.</u>		LENGTH OF STAY (in this place) <u>16 yrs.</u>		CITY OR TOWN <u>Odenton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>477</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Goble Wiley Jordan</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 23 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 1, 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Jordan</u>				14. MOTHER'S MAIDEN NAME <u>Cordie Cantwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT & ADDRESS <u>James Jordan, 308 8th Ave SE, Glen Burnie, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. IMMEDIATE CAUSE (A) <u>Collapsed Left Lung</u>				<u>3 weeks</u>			
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Emphysema</u>				<u>11 years</u>			
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Bronchial Asthma</u>				<u>15 years</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 19 46</u> , to <u>Jan 23 19 56</u> , that I last saw the deceased alive on <u>Jan 20 19 56</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Smith</u>				ADDRESS (Street, city, town, state) <u>6221 173 Rd 12316</u>			
M.D. <u>6221 173 Rd 12316</u>				DATE SIGNED <u>1 23 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. RECEIVED BY REGISTRAR <u>Jan. 25, 1956</u>		REGISTRAR'S SIGNATURE <u>Clara Hachup</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James J. C. Hickey</u>			
DATE				ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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JAN 25 1901

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. ... 28

162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>4yr. 9mos. 17days</u>		TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>330 Blooms Court</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ida</u> (Middle) <u>Mae</u> (Last) <u>Kelly (Brooks)</u>				(Month) <u>1</u> (Day) <u>19</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Female</u>	<u>Negro</u>	<u>Married</u>	<u>Unknown</u>	<u>42?</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				<u>Sudden</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Pneumonia - Chronic Brain Syndrome associated with Central Nervous System Syphilis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/2</u> , 19 <u>51</u> , to <u>1/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>56</u> , and that death occurred at <u>5:15pM</u> , from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict, M. D.</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>1/20/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-23-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Albans Cemetery</u>		LOCATION (City, town, or county) <u>A.A. Co. Md.</u>	
24. RECEIVED BY REGISTRAR <u>Jan. 25, 1956</u>		REGISTRAR'S SIGNATURE <u>26. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Adolphus Halstead</u>		ADDRESS <u>2918</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

23.11.19

6.11.19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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(#10) MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 25

1. PLACE OF DEATH:

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Brooklyn

LENGTH OF STAY (If this place)
4 HoursHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Arundel Park

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN Baltimore

STREET
ADDRESS

(If rural, give location)

957 Jack Street

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

THERESA

KELLY

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

1

29

1956

5. SEX:

Female

6. COLOR OR
RACE:

White

7. SINGLE. MARRIED.
WIDOWED. DIVORCED.
(Specify)

Married

8. DATE OF BIRTH:

Dec. 15, 1928

9. AGE last birthday:

27 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):

School teacher schools

10b. KIND OF BUSINESS OR
INDUSTRY:

Balto. Md.

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME:

Peter Giza

14. MOTHER'S MAIDEN NAME:

Julia Czaja

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No:

None

17. INFORMANT & ADDRESS:

Lyston Kelly 957 Jack St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Carbon Monoxide Poisoning

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b) Extensive 3rd Degree Burns of Body

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATHII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY Public Hall

21c. (City or town)

(County)

(State)

Arundel Park

Anne Arundel

Md.

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY 1 29 56 5P.M.21e. INJURY OCCURRED
While at Not while
work ☐ at work ☒

21f. HOW DID INJURY OCCUR?

Conflagration of Public Hall

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER ☒ DATE SIGNED
DEPUTY MEDICAL EXAMINER ☐
M. D. ASSISTANT MEDICAL EXAM. ☐

1/31/56

23. BURIAL, CREMATION,
REMOVAL (Specify):

Burial

DATE THEREOF

2/2/56

NAME OF CEMETERY OR CREMATORY

Holy Cross

LOCATION (City, town, or county)

(State)

A.A.Co.Md.

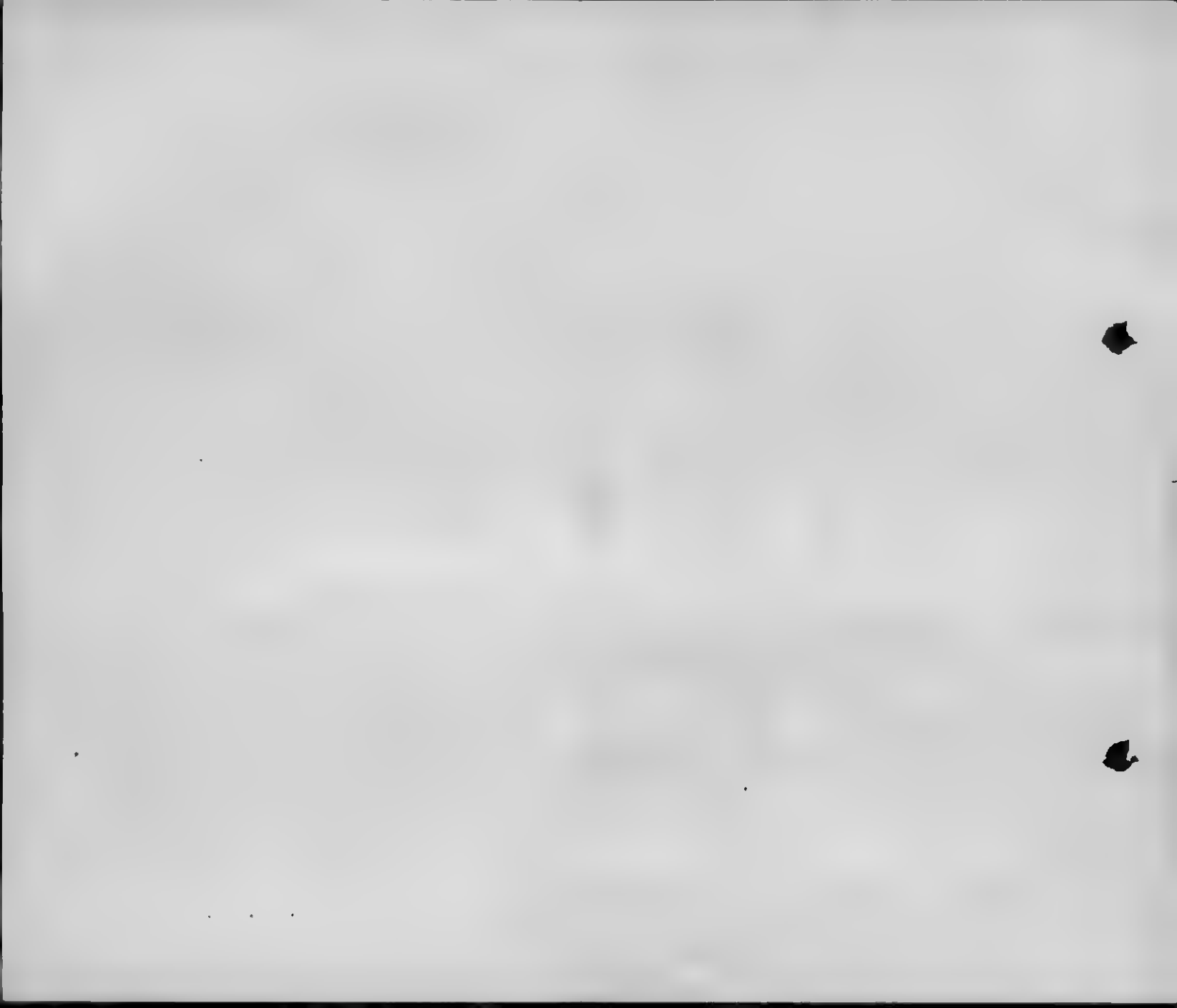
DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Wm. S. Fialkowski 2007 Eastern Av



CERTIFICATE OF DEATH

Reg. Dist. No. 21

164

1. PLACE OF DEATH:

COUNTY ANNE ARUNDEL MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) PASADENA
 OR TOWN PASADENA LENGTH OF STAY (in this place) LIFE
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY A.A.
 CITY (If outside corporate limits, write RURAL and give nearest town) PASADENA P.O.
 OR TOWN PASADENA P.O.
 STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

ANNIE MARIA KESS

4. DATE OF DEATH:

(Month)

(Day)

(Year)

131956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FEMALEColoredW. Dow3/17/186887 yrs.9 Months16 Days

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

NORETIREDM.D. WIFEPASADENA A.A. Co. MD.U.S.A

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma of uterus

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

6 months

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Conjunctive Heart Failure

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 10, 1956, to Jan. 3, 1956, that I last saw the deceasedalive on Jan. 2, 1956, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

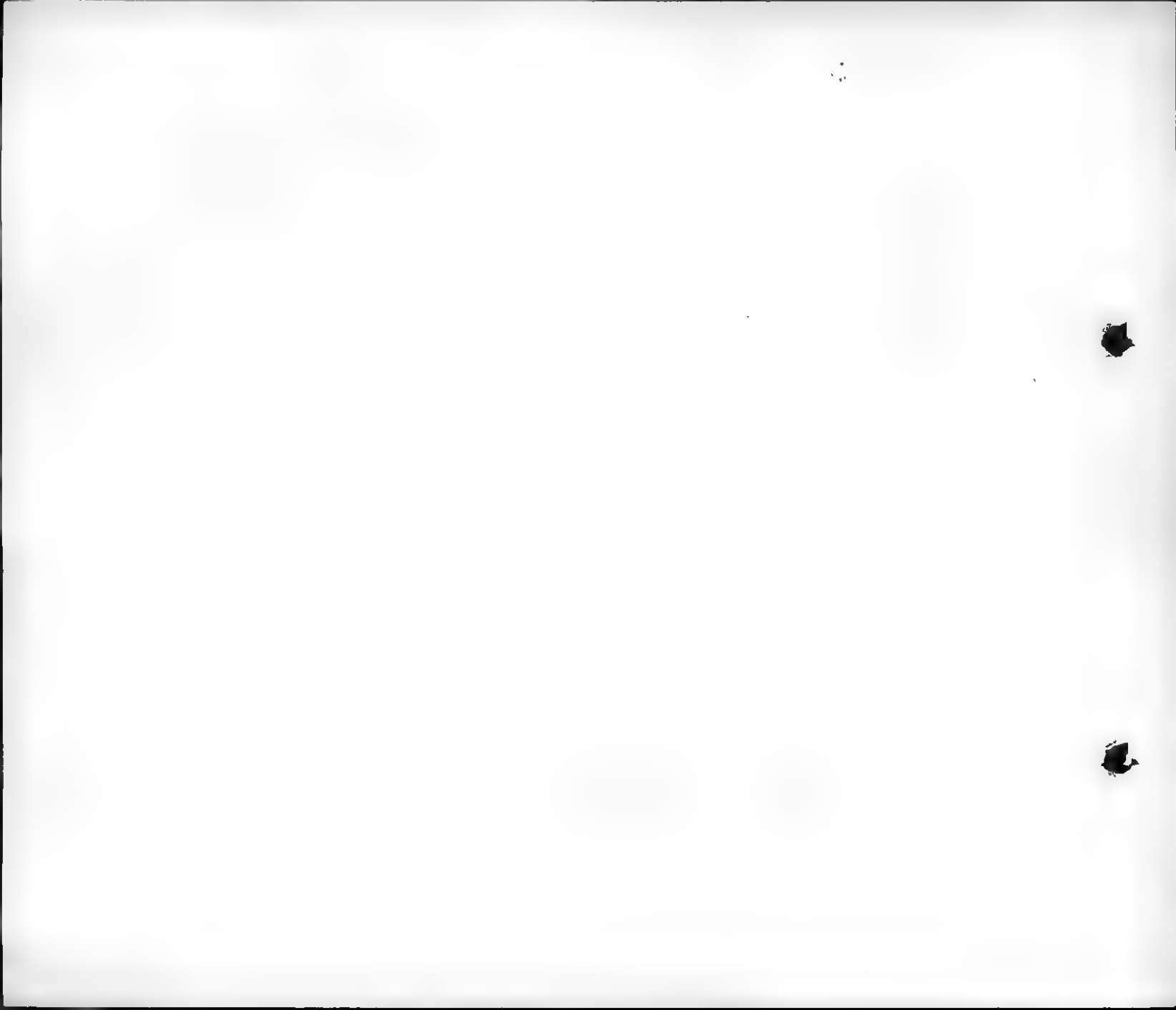
24. FUNERAL DIRECTOR

ADDRESS

BURIAL1/8/1956Mt Zion ChurchMAGOTHY - A.A. Co. MDMD1-1-56LMarshall P. Hayes638 N. GILMER STBALTO - 12 - MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00145

165

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE ARUNDEL		MARYLAND		STATE MARYLAND		COUNTY ANNA ARUNDEL	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN RIVIERA BEACH		(9 MOS.)		TOWN RIVIERA BEACH PASADENA MD.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS GREENWAY ROAD BOX # 247				STREET ADDRESS (If rural give location) GREENWAY ROAD BOX # 247			
3. NAME OF DECEASED (First) (Middle) (Last) CHARLES FRANCIS KNELL (Type or Print)				4. DATE OF DEATH JAN. 5, 1956 19			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER	8. DATE OF BIRTH MAY 23, 1895	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATIONARY ENG. SCHOOL DEPT. BALTO.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE KNELL				14. MOTHER'S MAIDEN NAME SALLY GIBBNEYS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-22-4626		17. INFORMANT & ADDRESS MRS WILLIAM HAUBROE SAME.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Carcinoma of Lung						4 years	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 2</u> , 19 <u>55</u> , to <u>Jan. 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 5</u> , 19 <u>56</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>H. M. McLaughlin</u> M.D.				ADDRESS (Street, city, town, state) <u>Pasadena, Md.</u>		DATE SIGNED <u>Jan. 6, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF 1/7/56		NAME OF CEMETERY OR CREMATORY GLEN HAVEN PARK		LOCATION (City, town, or county) (State) GLEN BURNIE MD.	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE <u>L. J. Doherty</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HENRY SANDER & SONS INC. <u>J. Sander</u> BALTIMORE MARYLAND			

1000

#3)

166

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

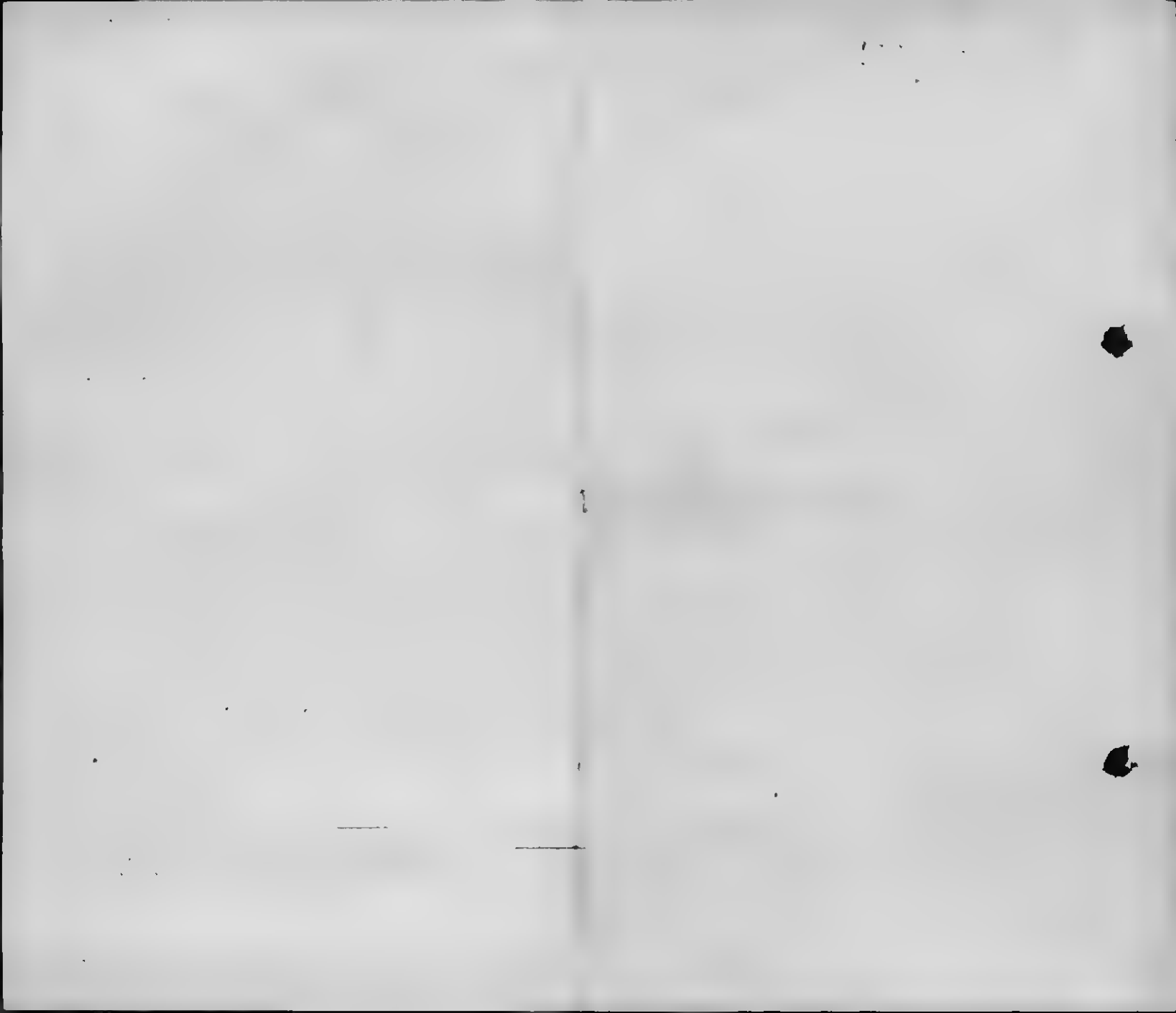
00146

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 25

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN Brooklyn		4 Hours		TOWN Baltimore		25	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Arundel Park				STREET ADDRESS (If rural, give location) 5627 Sagra Road			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print) STELLA		KOZLOWSKI		1		29 19 56	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Single	Feb. 25, 1908	47	Yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Laboratory in Chemical plant				Balto. Md.		U.S.A.	
13. FATHER'S NAME: Joseph Kozlowski				14. MOTHER'S MAIDEN NAME: Apolonia Grozinski			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 213-01-9511		17. INFORMANT & ADDRESS: Elizabeth Dulaney 5627 Sagra Road			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Carbon Monoxide Poisoning							
DUE TO							
Antecedent cause(s) (b) Extensive 3rd Degree Burns of Body							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Public Hall		21c. (City or town) Arundel Park		(County) Anne Arundel	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 1 29 56 5P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Conflagration of Public Hall			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER		DATE SIGNED	
R. F. Fisher				DEPUTY MEDICAL EXAMINER		1/31/56	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/3/56		St. Stanislaus		Balto. City Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
2-1-56		G. W. Hedrich		Wm. S. Fialkowski		2007 Eastern Ave.	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00147

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Jessup (Rural)</u>	<u>12 yrs</u>	OR TOWN <u>Jessup</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montevideo Rd</u>		STREET ADDRESS (If rural give location) <u>Box 361</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) <u>William Edward Lancaster</u>		(Month) (Day) (Year) <u>Jan 10 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan 21 1872</u>
9. AGE last birthday: <u>83</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	
11. BIRTHPLACE (State or foreign country): <u>Harper's Ferry, W.Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Lancaster</u>		14. MOTHER'S MAIDEN NAME: <u>Jane Cook</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-6587</u>	
17. INFORMANT & ADDRESS: <u>Miss Martha Lancaster, Box 361, Montevideo Rd, Jessup, Md</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Chr Myocarditis</u>		<u>5 yrs</u>	
ANTECEDENT CAUSE (B) <u>Decompensation</u>		<u>6 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility</u>		<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 1950</u> to <u>Jan 10, 1956</u> , that I last saw the deceased alive on <u>Jan 9, 1956</u> , and that death occurred at <u>2 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. B. Beurnbraugh</u>		DATE SIGNED <u>Jan 13 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem Park</u>	
DATE THEREOF <u>Jan 13 1956</u>		LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 13 1956</u>		24. FUNERAL DIRECTOR <u>W. B. Beurnbraugh</u>	
REGISTRAR'S SIGNATURE <u>W. B. Beurnbraugh</u>		ADDRESS <u>1000 ...</u>	

BUREAU A. J.

JAN 17 1968

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

168

CERTIFICATE OF DEATH

00148

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural- Arnold</u>		<u>DOA</u>		TOWN <u>U. S. Naval Barracks</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>USNH, Annapolis, Md.</u>				STREET ADDRESS (If rural give location) <u>Annapolis, Maryland</u>			
3. NAME OF DECEASED (Type or Print) <u>John Elmer LEMMONS, Jr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 1 19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Feb. 15, 1930</u>	
9. AGE last birthday <u>25</u> yrs.		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)		IF UNDER 24 HRS. (Hours) (Min.)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Elmer Lemmons, Sr.</u>				14. MOTHER'S MARDEN NAME <u>Dorothy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes 6-25-48 to present</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Official Navy Records</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
IMMEDIATE CAUSE (A) <u>Traumatic rupture right main bronchus</u>				IMMEDIATE CAUSE (A) <u>right pulmonary artery and vein N862</u>			
ANTECEDENT CAUSE(S) DUE TO				ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST.				STATING UNDERLYING CAUSE LAST.			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Street</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Rural AA Md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan 1 561:56pm</u>		21e. INJURY OCCURRED While at work Not while at work <input type="checkbox"/> <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Three car collision</u>			
22. I hereby certify that I attended the deceased from 1-1-56, 1956, to 1-1-56, 1956, that I last saw the deceased alive on DOA, and that death occurred at DOA, M, from the causes and on the date stated above.							
SIGNATURE OF REGISTRAR <u>[Signature]</u>				DATE SIGNED <u>Jan. 3, 1956</u>			
ADDRESS (Street, city, town, state) <u>M.D. U.S. Naval Hospital, Annapolis, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>Jan 3, 1956</u>		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>			
DATE <u>Jan. 3, 1956</u>				ADDRESS <u>Annapolis, Md.</u>			

S. V. S.

1915

169

CERTIFICATE OF DEATH

Reg. Dist. No. 24

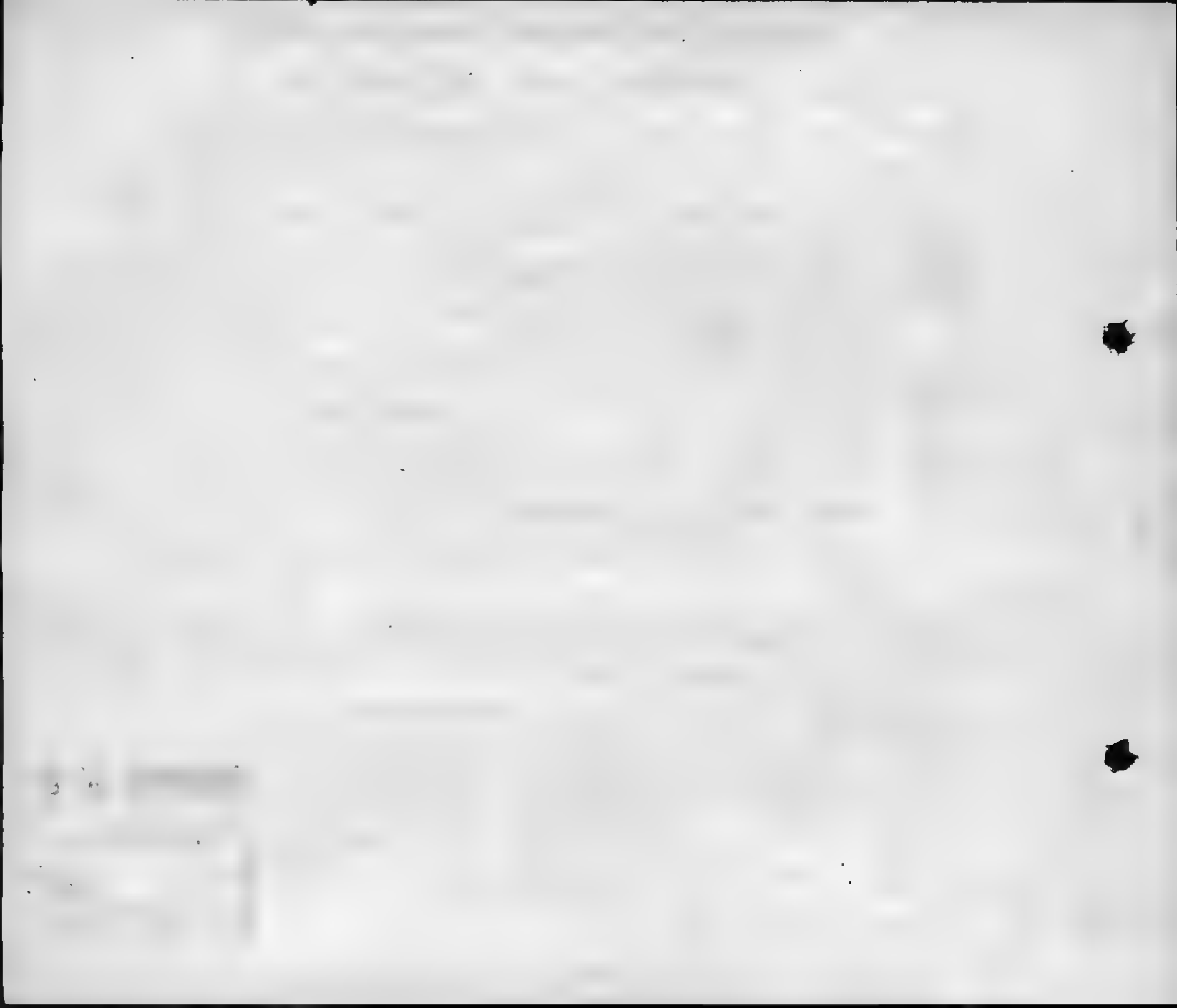
INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> <u>County</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> TOWN <u>Severna Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Highway</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>M.D.</u> COUNTY <u>A. A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park MD</u> TOWN <u>Severna Park</u> STREET ADDRESS (If rural give location) <u>Ritchie Highway</u>			
3. NAME OF DECEASED (Type or Print) <u>John Nicholas Madary</u> (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 27</u> <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 8 1776</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman, Fertilizer</u>			11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>501-123-4567</u>				
17. INFORMANT & ADDRESS <u>Son, Melvin W. Madary</u>				18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X IMMEDIATE CAUSE (A) Cerebral Hemorrhage.</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio Vascular Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized arteriosclerosis</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				21. MEDICAL CERTIFICATION (Continued)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. et work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>27 Jan 1956</u> to <u>27 Jan 1956</u> , that I last saw the deceased alive on <u>27 Jan 1956</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>G. Hahn</u> M.D.				DATE SIGNED <u>27 Jan 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>1-30-56</u>		NAME OF CEMETERY OR CREMATORY <u>GLENN HAVEN</u>		LOCATION (City, town, or county) (State) <u>BALTO</u>	
24. REC'D BY REGISTRAR <u>JAN 30 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. Sullivan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>McCully</u> ADDRESS <u>FUNERAL HOMES</u>			



117

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Annapolis</u>				OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>5321 Park Hts. Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>EDWARD</u> (First) <u>MARCUS</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY</u> <u>12</u> <u>19</u> <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 23, 1903</u>		9. AGE last birthday <u>52</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) <u>12</u> <u>19</u> <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>dress shop</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Barney Marcus</u>				14. MOTHER'S MAIDEN NAME <u>Yetta Goldman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Rena B. Marcus- wife -same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				<u>1 day</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 11, 1956</u>, to <u>Jan 12, 1956</u>, that I last saw the deceased alive on <u>Jan 11, 1956</u>, and that death occurred at <u>5:45</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				DATE SIGNED <u>1/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 15, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR <u>1-14-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING COUNTRY HOME ANNAPOLIS, MD.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

JAN 17 1956

BUREAU V. 8

118

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Anne Arundel</i>	STATE <i>Maryland</i>	COUNTY <i>G.A.</i>	
CITY OR TOWN <i>Annapolis</i>	LENGTH OF STAY (in this place)	CITY OR TOWN <i>Annapolis</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>18 Fleet St.</i>	STREET ADDRESS <i>18 Fleet St.</i>		
3. NAME OF DECEASED		4. DATE OF DEATH	
<i>Frank Matthews</i>		<i>1 10 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Specify)	8. DATE OF BIRTH <i>9-30-1897</i>
			9. AGE last birthday <i>58</i> yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. PLACE OF BIRTH (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
<i>Captain</i>		<i>Shadeside, Md. U.S.A.</i>	
13. FATHER'S NAME <i>Henry Matthews</i>		14. MOTHER'S MAIDEN NAME <i>Loell Scott</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
		17. INFORMANT'S NAME & ADDRESS <i>Sadie Matthews - Annapolis, Md.</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Cardiac Asthma</i>			<i>7 days</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cardiac Failure</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1/1</i> , 19 <i>56</i> , to <i>1/10</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1/10</i> , 19 <i>56</i> , and that death occurred at <i>10 A</i> .M. from the causes and on the date stated above.			
SIGNATURE <i>Shelby L. Johnson</i>		DATE SIGNED <i>1/12/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>St. Matthews</i>	
DATE THEREOF <i>1-13-56</i>		LOCATION (City, town, or county) (State)	
		<i>Shadeside, Md.</i>	
25. REC'D BY REGISTRAR		26. FUNERAL DIRECTOR'S SIGNATURE	
DATE <i>1-16, 1956</i>		<i>William Reese, Jr.</i>	
REGISTRAR'S SIGNATURE		ADDRESS	
		<i>Annapolis, Md.</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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JAN 17 1962

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119

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>Q.Q.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Q.Q.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>518 First St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Gertrude M. Matzen</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 - 23 - 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>1-31-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>59</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jus Matzen</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Wm H. Roche Annapolis Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Drowning

INTERVAL BETWEEN ONSET AND DEATH

Sudden

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Sawed overland - for Creek.

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE

(Describe or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 24, 1956J. J. DanielJohn M. Taylor Sons Annapolis Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 25 1956
BUREAU V. S.

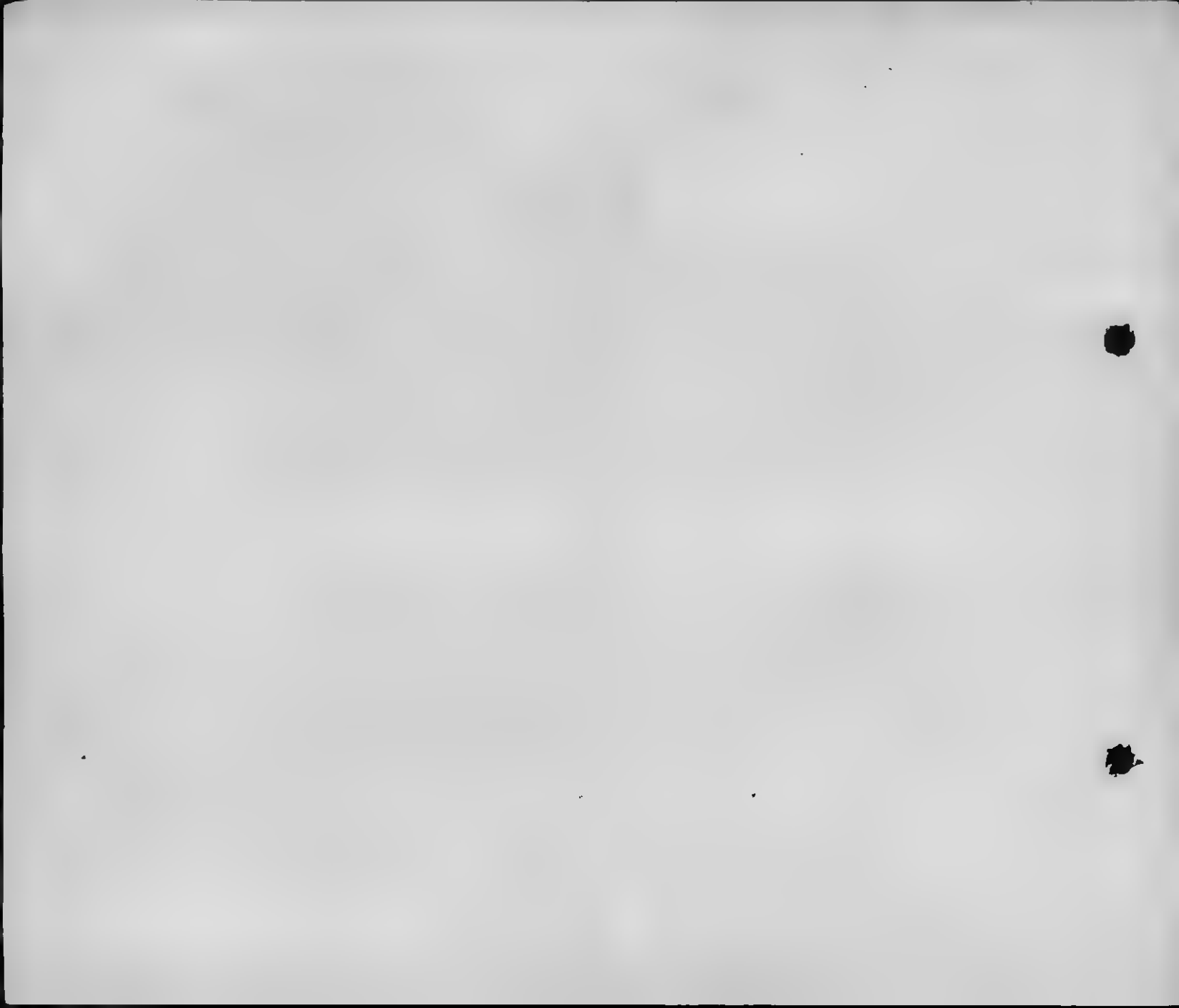
(78) MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 25

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Brooklyn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ARUNDEL PARK BELLE GROVE RD.</u>		STREET ADDRESS (If rural, give location) <u>804 Drill Court</u>	
3. NAME OF DECEASED: (Type or Print)	(First) <u>GLADYS</u>	(Middle) <u>MCKAY</u>	(Last)
4. DATE OF DEATH	(Month) <u>1</u>	(Day) <u>29</u>	(Year) <u>19 56</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>MAY 31, 1914</u>
9. AGE last birthday: <u>41</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>H.W.</u>	10b. KIND OF BUSINESS OR INDUSTRY: <u>C.H.</u>	11. BIRTHPLACE (State or foreign country): <u>BALTO. MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>WALTER E MARTIN</u>		14. MOTHER'S MAIDEN NAME: <u>LILLIAN BUDDENBOM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: <u>MIR. GEORGE MCKAY, 804 DRILL COURT.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a).....	<u>Carbon Monoxide Poisoning</u>	
DUE TO		
Antecedent cause(s) (b).....	<u>Extensive 3rd Degree Burns of Body</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)	DUE TO	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Public Hall</u>	21c. (City or town) (County) (State) <u>Arundel Park Anne Arundel Md.</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1 29 56 5P.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Conflagration of Public Hall</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>[Signature]</u>	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM <input type="checkbox"/>	DATE SIGNED <u>1/31/56</u>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>	DATE THEREOF <u>FEB. 3/56</u>	NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>
LOCATION (City, town, or county) (State) <u>ANNE ARUNDEL CO. MD.</u>	24. FUNERAL DIRECTOR <u>Harry H. White, 4101 EDMONDSON AVE.</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00154

171

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Pasadena</u>				Pasadena - R. F. D. 6-Box 80			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
X <u>Patasco Club, Rock Creek</u>				<u>Rock Creek -</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MABEL</u> (Middle) <u>BENNETT</u> (Last) <u>MILES</u>				Jan. 21, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	Sept. 9, 1890	65 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>at Home</u>		<u>Md.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel Bennett</u>				<u>Elizabeth Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
--		<u>none</u>		<u>Rock Creek, Pasadena P.C. RD 6</u> <u>Mr. W. Harold Miles</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
157X IMMEDIATE CAUSE (A) <u>Carcinoma of the body of the pancreas</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes mellitus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>260X</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				3 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 23, 1950</u> to <u>January 11, 1956</u> , that I last saw the deceased alive on <u>January 11, 1956</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. M. McLaughlin</u>				ADDRESS (Street, city, town, state) <u>Pasadena, Md.</u>		DATE SIGNED <u>January 11, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/4/56</u>		<u>Loudon Park Cem.</u>		<u>Balto., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE		<u>L. J. L. Davis</u>		<u>Wm. J. Pickens & Sons - Balto</u>		<u>17</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00155

CERTIFICATE OF DEATH

Reg. Dist. No. 21

120

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Annapolis</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Annapolis</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>431 State St.</i>		STREET ADDRESS (If rural give location) <i>431 State St.</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Guenter P.</i> (Middle) <i>Molden</i> (Last)		(Month) <i>1</i> (Day) <i>15</i> (Year) <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>6-29-1892</i>
9. AGE last birthday <i>63</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
		Months	Days
		Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Automobile</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Not Known</i>		14. MOTHER'S MAIDEN NAME <i>Not Known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <i>Mrs. G. P. Molden #2</i>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
I. IMMEDIATE CAUSE (A) <i>UREMIA</i>			<i>7 DAYS</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>NEPHROSCLEROSIS</i>			<i>7-3 YRS.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>ARTERIOSCLEROSIS</i>			<i>UNKNOWN</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <i>JUNE 14, 1955</i> , to <i>15 JAN 1956</i> , that I last saw the deceased alive on <i>14 JAN 1955</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Edward J. Beck Sr.</i>		DATE SIGNED <i>1/16/56</i>	
M.D. <i>4 South St. Annapolis Md</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		24. REC'D BY REGISTRAR	
DATE THEREOF <i>1-12-56</i>		NAME OF CEMETERY OR CREMATORY <i>H. Lincoln</i>	
LOCATION (City, town, or county) <i>Prince George Co. Md.</i>			
25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons</i>		ADDRESS <i>Annapolis, Md.</i>	
DATE <i>Jan. 18, 1956</i>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

JAN 19 1956

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00156

172

CERTIFICATE OF DEATH

Reg. Dist. No. 24

Item 2, File G191 1-16-56 et

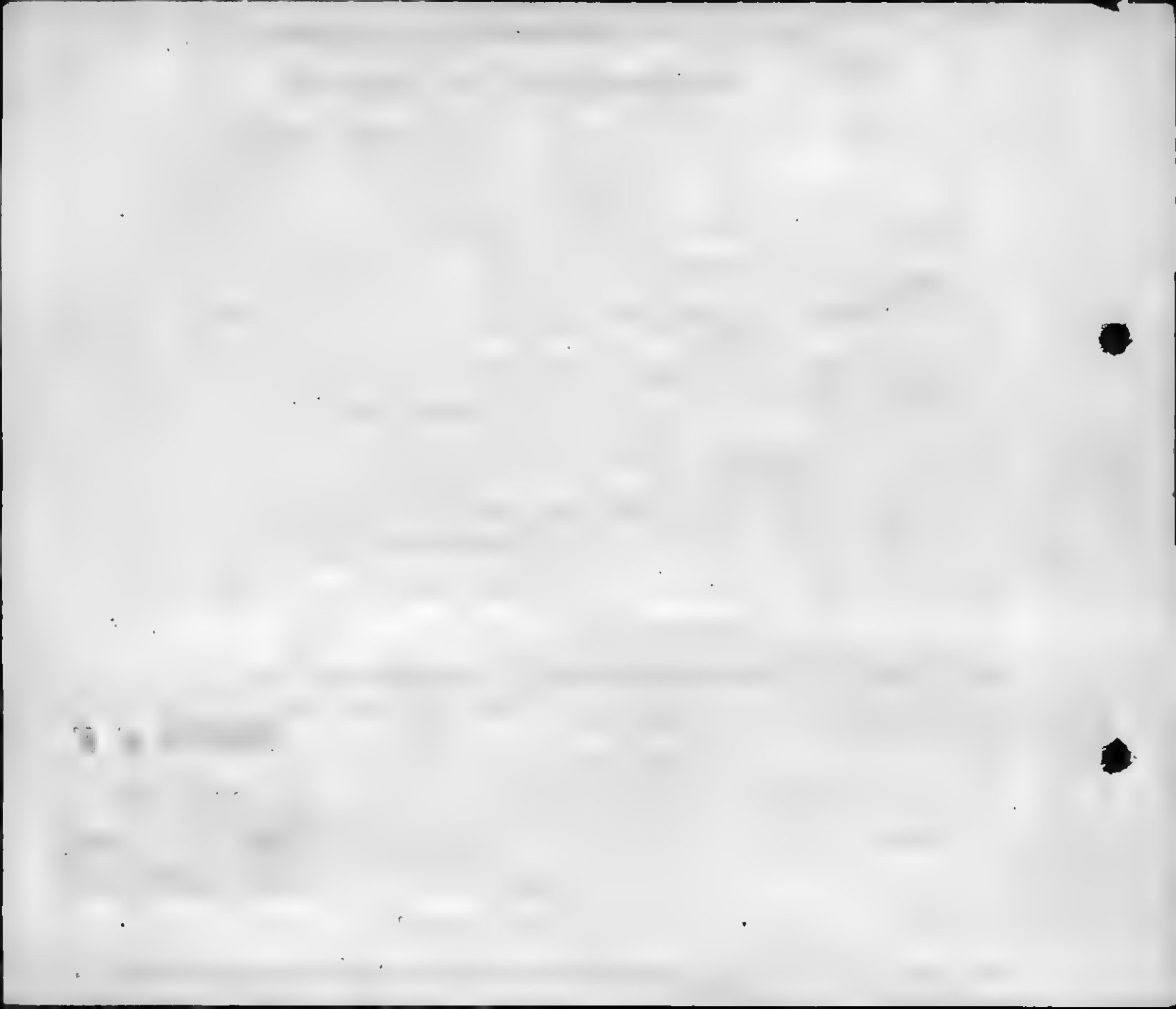
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Linthicum</u>		<u>3 yrs.</u>		TOWN <u>Garland (Linthicum Hgts. P.O.)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>221 Poplar ave</u>				STREET ADDRESS (If rural give location) <u>221 Poplar Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>Anna Frances</u> (First) <u>Munson</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>18</u> (Year) <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Mar.</u>	8. DATE OF BIRTH <u>July 17 '88</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Casey</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Robert C. Munson.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				<u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes</u>				<u>1962</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/18</u> , 19 <u>56</u> , to <u>1/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>56</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Chas L Ball, Jr</u>		M.D. <u>Linthicum</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>1/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 21, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan 19-1956</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u>		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00157

121

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF BIRTH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Annapolis</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Annapolis</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>				TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>A. A. General Hosp.</i>				STREET ADDRESS (If rural give location) <i>69 514 Waterbury, Md</i>			
3. NAME OF DECEASED (Type or Print) <i>Baby</i>				4. DATE OF DEATH (Month) <i>1</i> (Day) <i>12</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>		8. DATE OF BIRTH <i>1-12-56</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <i>1</i> yrs. <i>12</i> Months <i>12</i> Days <i>12</i> Hours <i>12</i> Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>Wavian Neal</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT & ADDRESS <i>Anna Queen - Waterbury, Md</i>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
7. IMMEDIATE CAUSE (A) <i>Prenature delivery</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hr</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Abruptio placentae</i>				<i>48 hr</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/12</i> , 19 <i>56</i> , to <i>1/12</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1/12</i> , 19 <i>56</i> , and that death occurred at <i>11:45</i> P.M., from the causes and on the date stated above.							
SIGNATURE <i>Robert G. Dulin Jr.</i>				DATE SIGNED <i>1/13/56</i>			
ADDRESS (Street, city, town, state) <i>69 Franklin St. Annapolis, Md</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-14-56</i>		NAME OF CEMETERY OR CREMATORY <i>John Wesley</i>		LOCATION (City, town, or county) <i>Waterbury, Md</i>	
24. REC'D BY REGISTRAR <i>ff</i>		REGISTRAR'S SIGNATURE <i>ff</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr.</i>		ADDRESS <i>Annapolis, Md</i>	
DATE <i>1-16, 1956</i>							

RECEIVED

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RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

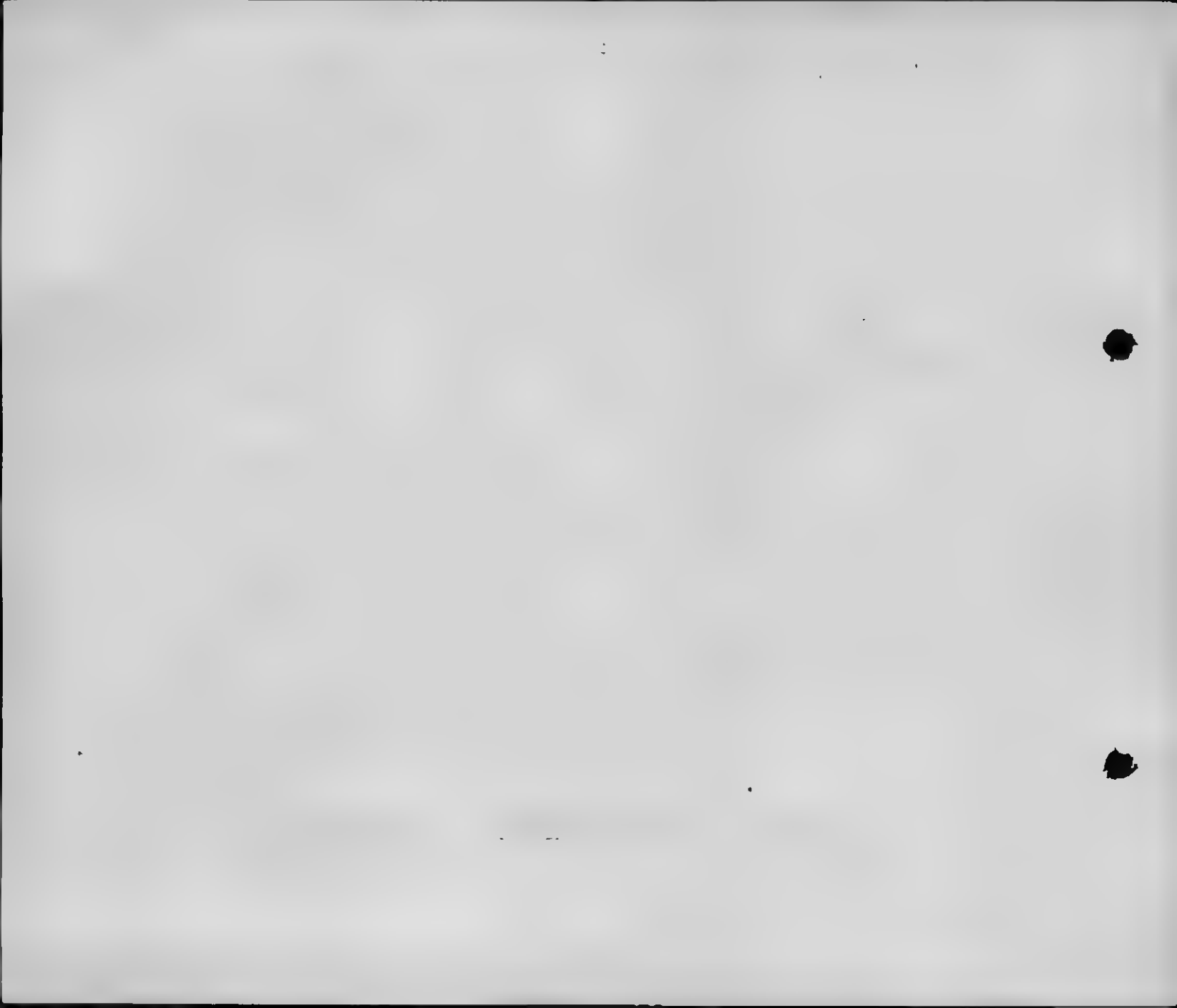
(#9) MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00158

Reg. Dist. 25

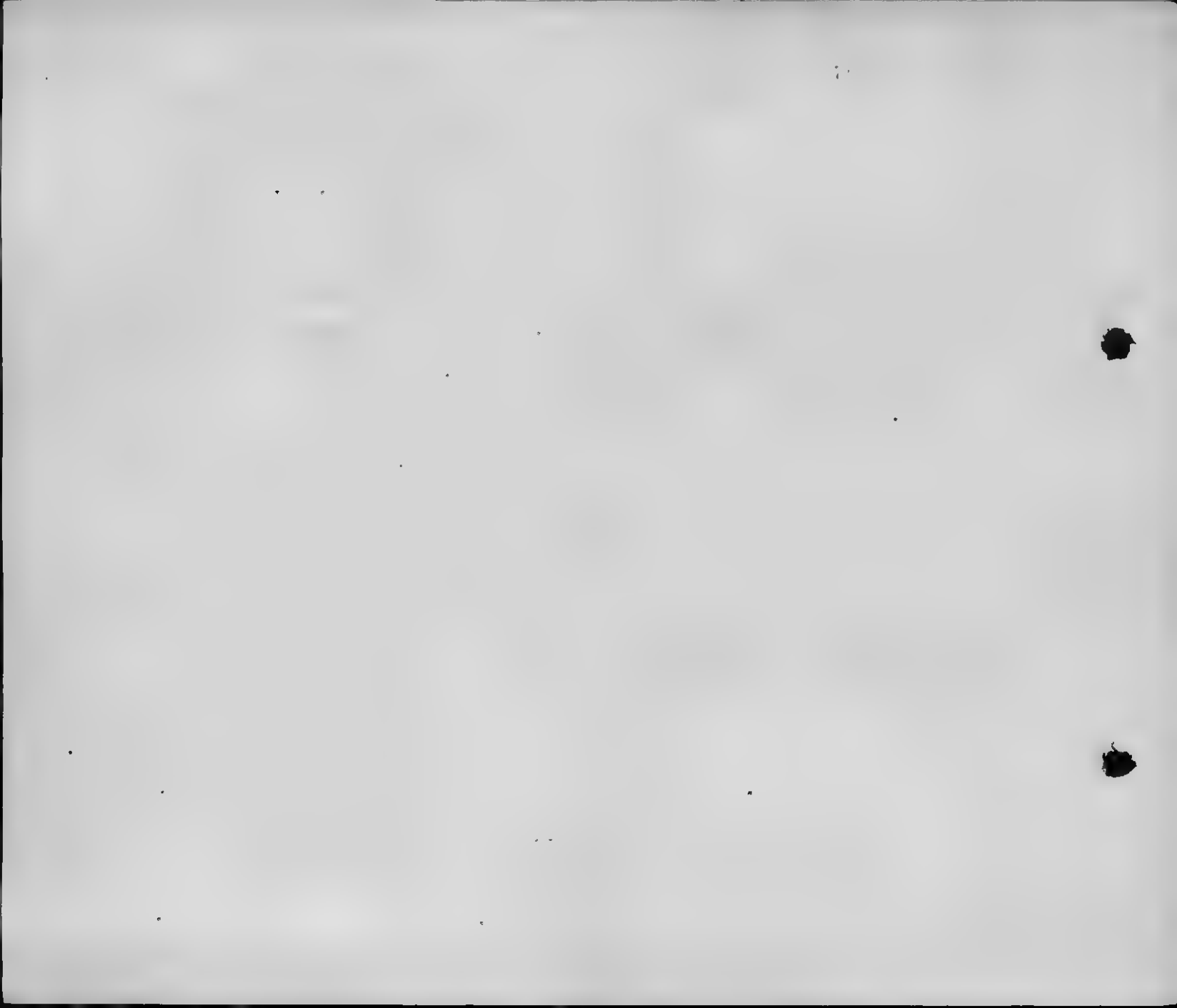
No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Brooklyn Park		LENGTH OF STAY (In this place) 1 day		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Baltimore Suburban			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Arundel Park 4901 Belle Grove Road				STREET ADDRESS (If rural, give location) 19 Seward Avenue			
3. NAME OF DECEASED: (Type or Print) FRANCES J.		(First) (Middle) (Last)		4. DATE OF DEATH		1 29 19 56	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed		8. DATE OF BIRTH: March 9, 1875	
9. AGE last birthday: 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife		10b. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs. Mary Jordan 204 10th Ave. Balto. 25, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) ... Carbon Monoxide Poisoning							
DUE TO							
Antecedent cause(s) (b) ... Extensive 3rd Degree Burns of Body							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:							19b. MAJOR FINDING OF OPERATION:
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Public Hall
21c. (City or town) (County) (State)							
Arundel Park Anne Arundel Md.							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 1 29 56 5P.M.							21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
21f. HOW DID INJURY OCCUR? Conflagration of Public Hall							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
				DATE SIGNED		1/31/56	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Feb. 2, 1956		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) (State) Ritchie Hwy. A. A. Co., Md.	
24. FUNERAL DIRECTOR		ADDRESS		George J. Gonce 4001 Ritchie Hwy. Balto. 25			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

174				00159	
#1) MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
No. 1					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Arundel Park</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Rockdale, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Public Hall</u>			STREET ADDRESS (If rural, give location) <u>8115 Liberty Road</u>		
3. NAME OF DECEASED: (Type or Print) <u>GOLDIE</u> (First) <u>Mae</u> (Middle) <u>OTTO</u> (Last)			4. DATE OF DEATH <u>1</u> (Month) <u>29</u> (Day) <u>19</u> (Year) <u>56</u>		
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 17, 1916</u>	9. AGE last birthday: <u>39</u> yrs.	IF UNDER 1 YEAR <u>3</u> Months <u>29</u> Days <u>19</u> Hours <u>56</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>5 & 10¢ store</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME: <u>David W. Stokes</u>		
14. MOTHER'S MAIDEN NAME: <u>Mammie Wine</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		
16. SOCIAL SECURITY No.:			17. INFORMANT & ADDRESS: <u>Mr. Roy E. Otto - 8115 Liberty Rd.</u>		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) ... <u>Carbon Monoxide Poisoning</u> DUE TO					
Antecedent cause(s) (b) ... <u>Extensive 3rd Degree Burns of Body</u> DUE TO					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Public Hall</u>		21c. (City or town) (County) (State) <u>Arundel Park Anne Arundel Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1 29 56 5P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Conflagration of Public Hall.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <u>1/31/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u> LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
DATE REC'D BY LOCAL REG. <u>2-2-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>[Signature]</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 21

122

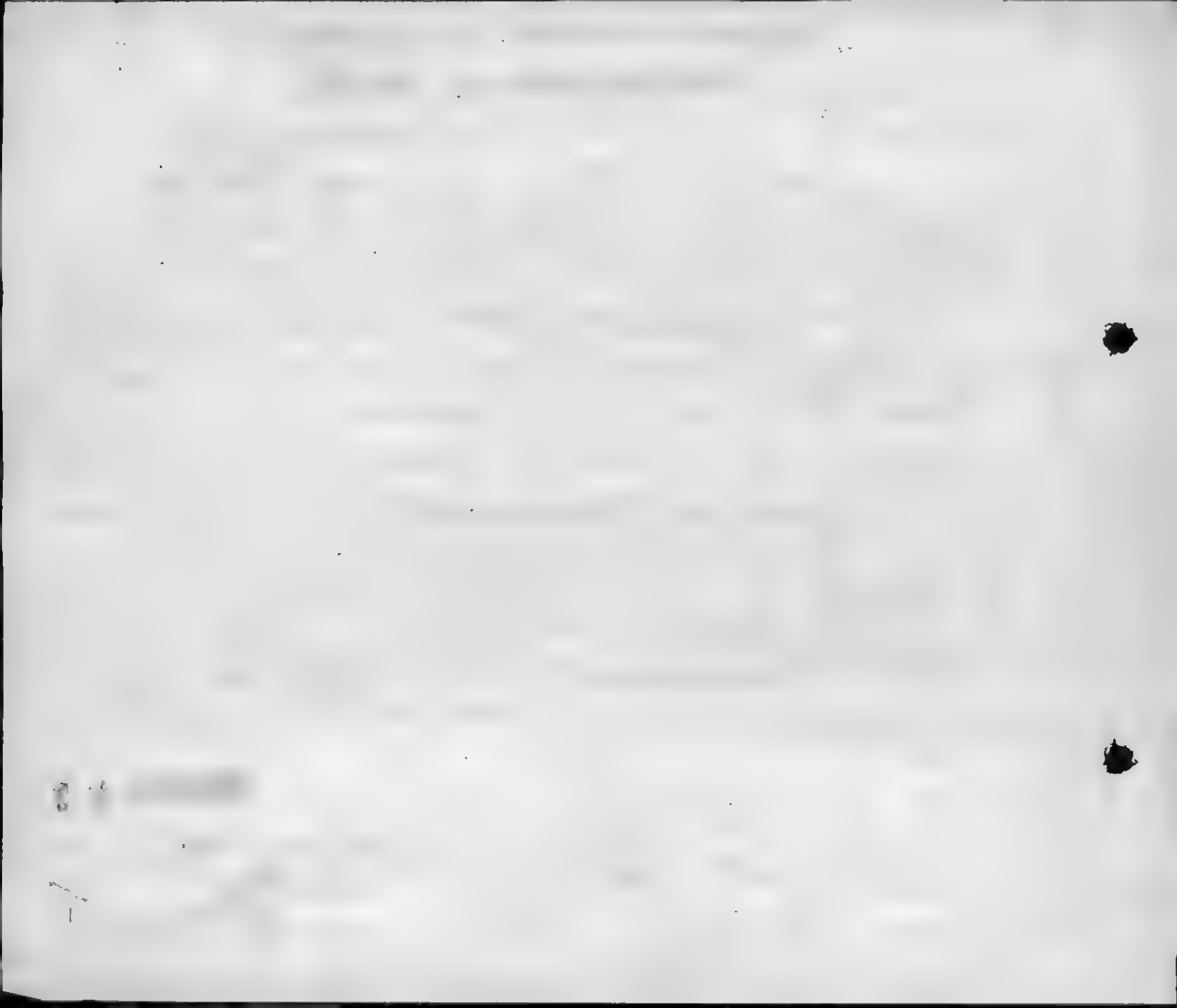
1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>ANNE ARUNDEL</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>ANNE ARUNDEL</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS MD.</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS MD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>194 Gloucester St.</u>		STREET ADDRESS <u>194 Gloucester St.</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE A. PAPPAS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 24 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED; (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Sept. 14 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STILLARD H-766</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STILLARD H-766</u>	9. AGE last birthday <u>62</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>GREECE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony Pappas</u>		14. MOTHER'S MAIDEN NAME <u>"UNK"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>ETHEL PAPPAS #2</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis - Cardio -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Vascular disease</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>January 1, 1954</u> to <u>Jan 24, 1956</u> , that I last saw the deceased alive on <u>1/24/56</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Albert H. Anderson</u>		DATE SIGNED <u>1/24/56</u>	
M.D.		ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>1/27/56</u>	NAME OF CEMETERY OR CREMATORY <u>CEDAR Bluff</u>	LOCATION (City, town, or county) <u>Annapolis, Md.</u>
24. REC'D BY REGISTRAR <u>John M. Taylor</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>	ADDRESS <u>Annapolis, MD.</u>
DATE <u>Jan. 26, 1956</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00161

123

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>A. A.</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>A A</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>ANNAPOLIS</u>		TOWN <u>ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>A A. GENERAL</u>		<u>600 STATE ST</u>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>ARTHUR T. PARKS</u>		<u>1-15-1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>6-16-1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>SALES MAN RET</u>			<u>BALTIMORE MD</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>WILLIAM D. PARKS</u>		<u>ANNIE C. WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
		<u>212-01-6199</u>	<u>LUCIELLE PARKS</u> (2) Wife
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)		<u>Electrocardiogram Left lung (Complete)</u>	
ANTECEDENT CAUSE(S) DUE TO		<u>Emphysema Chronic</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO		<u>Asthma Bronchial Chronic</u>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
		<u>1 hr.</u>	
		<u>8 yrs.</u>	
		<u>8 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>July 14, 1955</u> to <u>Jan 15, 1956</u> , that I last saw the deceased alive on <u>Jan 14, 1956</u> , and that death occurred at <u>Jan 15, 1956</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>John R. Martin</u>		<u>1-16-56</u>	
M.D.		ADDRESS (Street, city, town, state)	
		<u>Annapolis, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Cedar Bluff</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>1-18-56</u>		<u>Annapolis Md</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>J. J. Daniel</u>		<u>John M. Taylor Sons Annapolis Md</u>	
DATE <u>Jan 18, 1956</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00162

124

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>AA</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>AA</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>ANNAPOLIS</u>		TOWN <u>ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		<u>13 N. CHERRY GROVE AVE</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>MAGGIE MAE PERRY</u>		1 - 14 - 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>6-25-1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
<u>Housewife</u>		<u>Home</u>	<u>83</u> yrs.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Churchton Md.</u>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>William Dawson</u>		<u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>Unknown</u>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>Marguerite T. Polite</u>		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>	
		ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBRAL ARTERIO SCLEROSIS</u>	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)	
		20. INTERVAL BETWEEN ONSET AND DEATH	
		<u>2 DAYS</u>	
		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>13 DEC, 1955</u> to <u>13 JAN, 1956</u> , that I last saw the deceased alive on <u>13 JAN 1956</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
<u>Edward L. Beck M.D.</u>		<u>41 Southgate Ave. Annapolis, Md.</u>	
DATE		DATE SIGNED	
<u>Jan. 16, 1956</u>		<u>1/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>St James Cem</u>	
DATE THEREOF		LOCATION (City, town, or county)	
<u>1-16-56</u>		<u>Tracy's Landing Md.</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTER SIGNATURE		ADDRESS	
<u>John M. Taylor</u>		<u>Annapolis Md.</u>	

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1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00163

175

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL or and give nearest town) Crownsville		LENGTH OF STAY (in this place) 5 months		CITY (If outside corporate limits, write RURAL and give nearest town) Williamsburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) None listed			
3. NAME OF (First) (Middle) (Last) Walter Pinder				4. DATE (Month) (Day) (Year) DEATH 1 12 19 56			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 3/9/52	9. AGE last birthday 3 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Walter Pinder				14. MOTHER'S MAIDEN NAME Esther Nichols			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
301a IMMEDIATE CAUSE (A) Electrolyte imbalance due to Pylorospasm				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO Chronic Brain Sundrome associated with birth trauma and convulsive disorder				Known to us since 8/15/55			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/15, 1955, to 1/12, 1956, that I last saw the deceased alive on 1/12, 1956, and that death occurred at 11 P.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>		(S. Walker, M. D.) M.D.		ADDRESS (Street, city, town, state) Crownsville, Md.		DATE SIGNED 1/16/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF 1/19/56		NAME OF CEMETERY OR CREMATORY Skinner's Run Cemetery		LOCATION (City, town, or county) (State) Williamsburg Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>			
DATE 1-17-56				ADDRESS Don Ledererbury			



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

125

CERTIFICATE OF DEATH

00164

Reg. Dist. No. 21

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly shall be detached for use as a burial transit permit.

VS A158 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. General Hosp.</u>				STREET ADDRESS (If rural give location) <u>3 Brewer St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Stella</u> (Middle) <u>Queen</u> (Last)				(Month) <u>1</u> (Day) <u>3</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>5-28-1905</u>	9. AGE last birthday <u>50</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, avoid if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Ekla Sembley</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Adelle Murray-Annapolis, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. <input checked="" type="checkbox"/> IMMEDIATE CAUSE (A) <u>Ca of esophagus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sept 28-53</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastases in lung</u>				<u>Ca</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>secondary pneumonia</u>				<u>Jan 3, 56</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>hypertension</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 15, 1948</u> , to <u>1-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-3</u> , 19 <u>56</u> , and that death occurred at <u>11:40</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Edith Pooler</u>		ADDRESS (Street, city, town, state) <u>45 Franklin St Annapolis Md 1-4-56</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 5, 1956</u>		REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Bee...</u>		ADDRESS <u>108 Wash. St. Annapolis, Md.</u>	

[Faint handwritten notes]

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April 1954

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

176

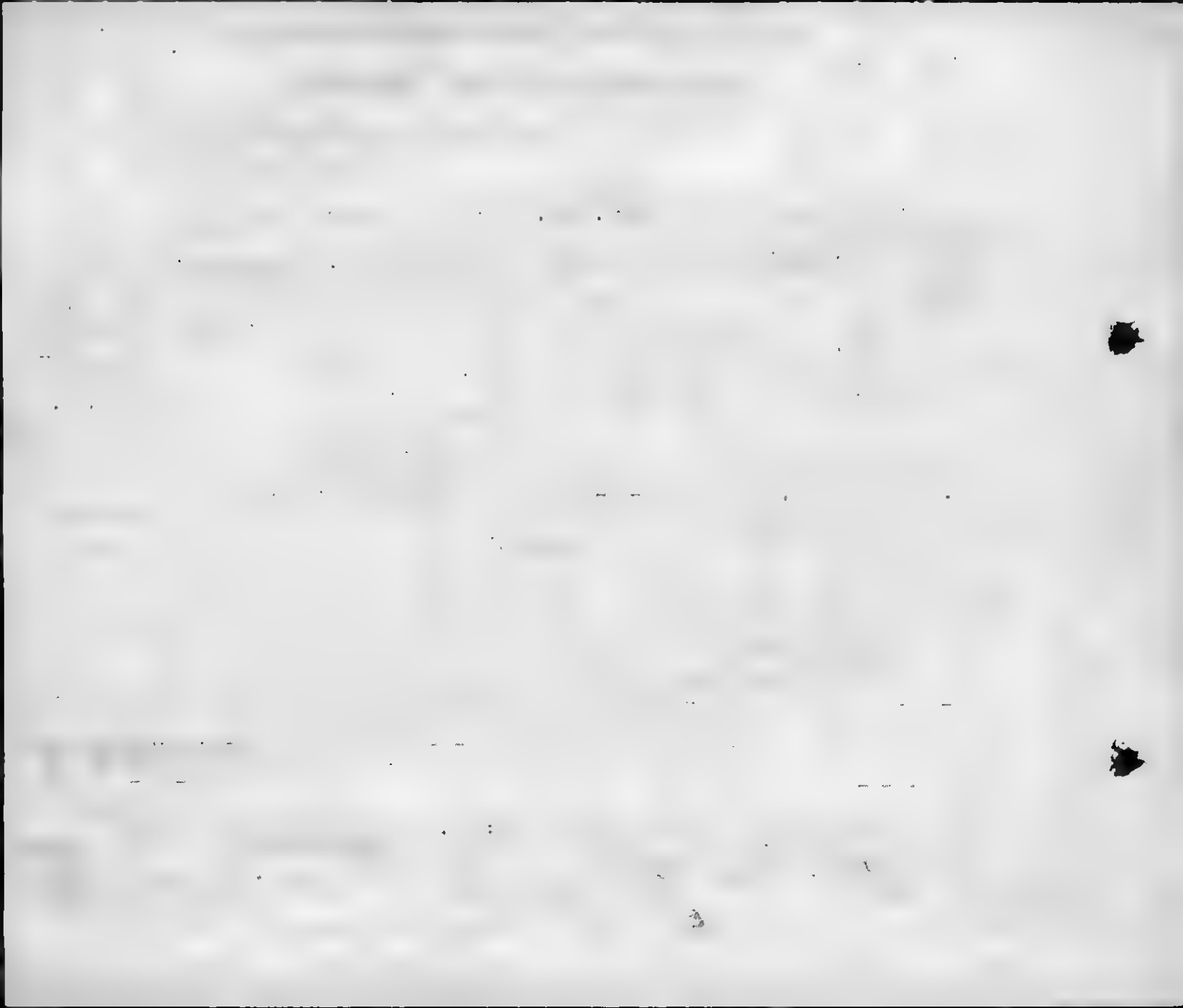
CERTIFICATE OF DEATH

00165

Reg. Dist. No. 28

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Anne Arundel | | STATE Maryland | | COUNTY Baltimore City | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN Crownsville | | 4yrs. 9mos. 27 days | | TOWN Baltimore City | | 8V01-4 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital | | | | STREET ADDRESS (If rural give location) 714 N. Stockton Street | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Thomas | | (Middle) Paul | | (Last) Robinson | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | | 8. DATE OF BIRTH Unknown | |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Grain Elevators | | 9. AGE last birthday 62? yrs. | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Samuel Robinson | | | | 14. MOTHER'S MAIDEN NAME Mary Ewell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk. | | 16. SOCIAL SECURITY NO. 705-10-5739 | | 17. INFORMANT & ADDRESS Hospital Records | | | |
| | | | | | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 1 day | |
| 57... IMMEDIATE CAUSE (A) Intestinal Obstruction | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 7/5, 1955 , to 1/11, 1956 , that I last saw the deceased alive on 1/11, 1956 , and that death occurred at 3:00 PM , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Cherett W. Cadenhead, M.D. | | | | ADDRESS (Street, city, town, state) Crownsville, Md. | | DATE SIGNED 1/12/56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF 1-16-56 | | NAME OF CEMETERY OR CREMATORY Mt. Auburn | | LOCATION (City, town, or county) (State) Baltimore Md | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE Dr. W. Joyce | | 25. FUNERAL DIRECTOR'S SIGNATURE William H. Phillips | | ADDRESS 180871. 2nd Ave | |
| DATE Jan. 16, 1956 | | | | | | | |

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00166

177

CERTIFICATE OF DEATH

Reg. Dist. No. 28

| | | | | | | | |
|--|---|---|---|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Anne Arundel | | STATE Maryland | | COUNTY Charles | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
Crownsville | | LENGTH OF STAY (in this place)
1 yr. 2 mos. 27 days | | CITY (If outside corporate limits, write RURAL and give nearest town)
Forklin | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
Crownsville State Hospital | | | | STREET ADDRESS (If rural give location)
None listed | | | |
| 3. NAME OF DECEASED (First) Josephine (Middle) (Last) Russell | | | | 4. DATE OF DEATH (Month) 1 (Day) 11 (Year) 19 56 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
Married | 8. DATE OF BIRTH
Not given | | 9. AGE last birthday
69? yrs. | IF UNDER 1 YEAR
Months - Days - Hours - Min. - | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | 10b. KIND OF BUSINESS OR INDUSTRY
- - - | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Jim Holley | | | | 14. MOTHER'S MAIDEN NAME
Birdie Holley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
Unk. | | 16. SOCIAL SECURITY NO.
unk. | | 17. INFORMANT & ADDRESS
Hospital Records | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) Pulmonary edema | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) CVA | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 10/15, 19 54, to 1/11, 19 56, that I last saw the deceased alive on 1/10, 19 56, and that death occurred at 2:35a.m. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<i>L. Benedict</i> | | (L. Benedict, M. D.) | | ADDRESS (Street, city, town, state)
Crownsville, Md. | | DATE SIGNED
1/11/56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | DATE THEREOF
1/14/56 | | NAME OF CEMETERY OR CREMATORY
Not identified | | LOCATION (City, town, or county) (State)
St. L. | |
| 24. REC'D BY REGISTRAR
DATE 1/11/56 | | REGISTRAR'S SIGNATURE
<i>H. M. Joyce</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<i>Robert H. Mc. Haire</i> | | ADDRESS
1820-4th St. Wash, D.C. | |

Inb-5936 - Fern Dir. - 265 H. ad. Dr.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00167

178

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>AN</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>AN</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Friendship</u> | | | | TOWN <u>Friendship</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Bertha R. Sweeney</u> | | | | 4. DATE OF DEATH <u>1 5 1956</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u> | | 8. DATE OF BIRTH <u>Oct 20 1873</u> | |
| 9. AGE last birthday <u>82</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William C. Fowler</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Lane</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Mrs Evelyn Putnam, Friendship</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Cardio vascular disease</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST, DUE TO | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>died sitting up in chair</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/> A. <input type="checkbox"/> N. <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 10 1956</u> to <u>1/7 1956</u> , that I last saw the deceased alive on <u>1/7 1956</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>H. J. Sweeney</u> | | | | DATE SIGNED <u>1/6/56</u> | | | |
| ADDRESS (Street, city, town, state) <u>1001 11/6/56</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>15 used</u> | | DATE THEREOF <u>1/7/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Friendship Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Elmer H. Williams</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Harry Hutchinson Jr</u> | | ADDRESS <u>Baltimore</u> | |
| DATE <u>1/7/56</u> | | | | | | | |



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CERTIFICATE OF DEATH

Reg. Dist. No. 27

| | | | | | | | |
|--|-------------------------------|---|---|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Wisconsin</u> | | COUNTY <u>La Crosse</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Fort George G. Meade, Md.</u> | | | | TOWN <u>La Crosse</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fort George G. Meade, Md.</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>RICKY</u> <u>JOE</u> <u>SCHAFFER</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>January 15</u> <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>-</u> | 8. DATE OF BIRTH <u>13 January 1956</u> | 9. AGE last birthday <u>-</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| | | | | | Months | Days | Hours Min. |
| | | | | | | | <u>38</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Fort George G. Meade, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>La Verne Fred Schaffer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Darlene Marie Engler</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT & ADDRESS <u>Father: 2071st ASU, Ft. Meade, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>Respiratory Failure</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>38 hrs</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Respiratory Failure</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Prematurity</u> | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prematurity</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>13 Jan</u> , 19 <u>56</u> to <u>15 Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>15 Jan</u> , 19 <u>56</u> , and that death occurred at <u>2</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>THOMAS A. COOK JR. MD.</u> | | | | ADDRESS (Street, city, town, state) <u>Fort George G. Meade, Md.</u> DATE SIGNED <u>16 January 56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY <u>Hakah Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Hakah, Minnesota</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>William L. Saylor</u> | | FUNERAL DIRECTOR'S SIGNATURE <u>William Cook</u> | | ADDRESS <u>Baltimore, Maryland</u> | |
| DATE <u>16 Jan 56</u> | | | | | | | |

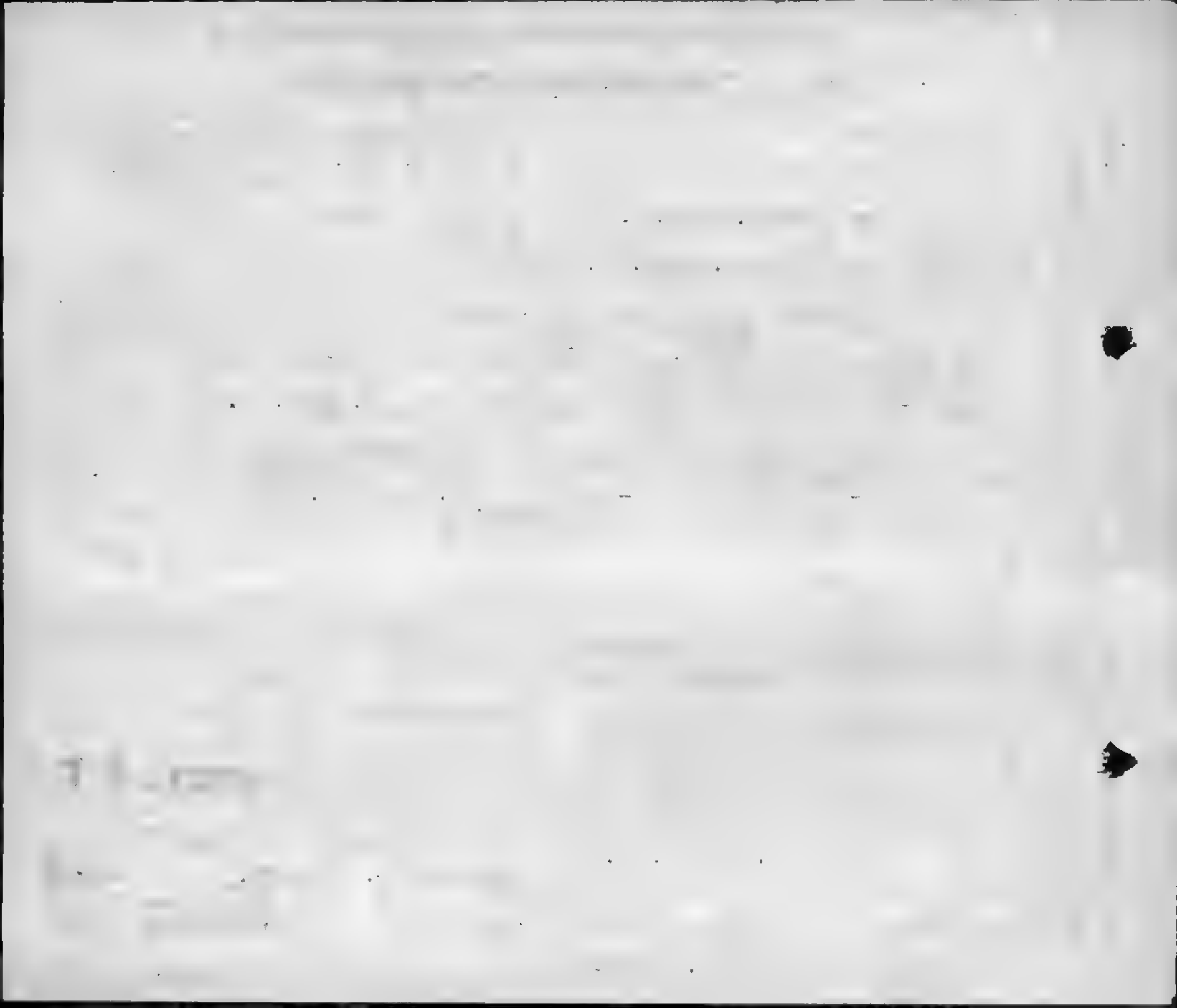
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 70M

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00169

24

| | | | | | | | |
|---|---------------------------|--|---------------------------------|---|---|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>A.A.</u> | | MARYLAND | | STATE <u>MD.</u> | | COUNTY <u>A.A.</u> | |
| CITY (If outside corporate limits, write RURAL or end give nearest town) <u>High St.</u> | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>High St.</u> | | TOWN <u>High St.</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9th St.</u> | | | | STREET ADDRESS (If rural give location) <u>9th St.</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>Michael S. Schultz</u> | | | | 4. DATE OF DEATH
(Month) <u>1</u> (Day) <u>9</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u> | 8. DATE OF BIRTH <u>4-16-88</u> | 9. AGE last birthday <u>67</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ALCOHOLIC</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>1540</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Frank</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Amelia</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or None) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Family - Same</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u> | | | | | | <u>5 years.</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from April 28, 1950, to January 4, 1956, that I last saw the deceased alive on January 9, 1956, and that death occurred at 5:10 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>R. M. McLaughlin</u> | | | | ADDRESS (Street, city, town, state) <u>Baltimore, Md.</u> | | DATE SIGNED <u>January 9, 1956</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF <u>1-13-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | LOCATION (City, town, or county) (State) <u>Baltimore</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Louis J. DeWitt</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>McLoughlin</u> | | ADDRESS <u>Home</u> | |
| DATE <u>JAN 13 1956</u> | | | | | | | |



CERTIFICATE OF DEATH

Reg. Dist. No. 21

126

| | | | | | | | |
|--|------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY ANNE ARUNDEL | | MARYLAND | | STATE MARYLAND | | COUNTY ANNE ARUNDEL | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN ANNAPOLIS | | 50 YRS. | | TOWN ANNAPOLIS | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 41 CATHEDRAL STREET | | | | STREET ADDRESS (If rural give location) 41 CATHEDRAL | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| HARRIETTE HARRIETT SELLMAN | | | | JANUARY 3, 1956 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| FEMALE | COLOR | WIDOWED | MARCH 12, 1880 | 75 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| DOMESTIC | | NONE | | ANNE ARUNDEL CO. MARYLAND | | ----- | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| GEORGE PRICE | | | | JULIA CULLY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| NO | | | | ANNAPOLIS, MARYLAND
JULIA JOHNSON 41 CATHEDRAL STREET | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) cerebral hemorrhage | | | | | | 12-30-55 | |
| ANTECEDENT CAUSE(S) DUE TO gen. arterio sclerosis | | | | | | Do | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Hypertension | | | | | | 1-3-56 | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Trophic ulcer of left leg | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 1-27, 1956, to 1-3, 1956, that I last saw the deceased alive on 12-31, 1956, and that death occurred at 9:45 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| Ethel L. Hicks | | | | 1-6-56 | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| BURIAL | | 1/6/1956 | | BREWER HILL CEMETERY | | WEST ST. ANNAPOLIS, MARYLAND | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE Jan. 6, 1956 | | J. French | | ETHEL L. HICKS-45 | | NORTHWEST ST.-ANNAPOLIS | |

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

J. V. S.

181

CERTIFICATE OF DEATH

Reg. Dist. No. 27

| | | | | | | | |
|--|------------------|--|------------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Illinois</u> | | COUNTY <u>McLean</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Fort George G. Meade</u> | | <u>22 hrs</u> | | TOWN <u>Bloomington</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>DEBRA</u> (Middle) <u>DENISE</u> (Last) <u>SHANKS</u> | | | | (Month) <u>January</u> (Day) <u>18</u> (Year) <u>19 56</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Single</u> | <u>17 January 1956</u> | <u>—</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>None</u> | | <u>None</u> | | <u>Maryland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>David James Shanks</u> | | | | <u>Elizabeth Ann Certig</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>None</u> | | <u>Father, 901 Park Avenue Laurel, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Atelectasis</u> <u>Atelectasis</u> | | | | | | <u>12 hrs 55mi</u> | |
| ANTECEDENT CAUSE(S) DUE TO <u>Hyaline Membrane Disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Pneumothorax</u> <u>Prematurity</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>17 Jan</u> , 19 <u>56</u> , to <u>18 Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>18 Jan</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>HERBERT L. NEEDLEMAN, MC</u> | | | | ADDRESS (Street, city, town, state) <u>Ft Gg Meade, Maryland</u> | | DATE SIGNED <u>18 Jan 56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | DATE THEREOF <u>19 Jan 56</u> | | NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u> | |
| 24. REC'D BY REGISTRAR <u>W.L. Saylor, 1st Lt MSC</u> | | | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Chaplain Johnson, Ft GG Meade, Md.</u> | | LOCATION (City, town, or county) <u>Fort Meade, Maryland</u> | |
| DATE <u>18 Jan 56</u> | | | | | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS AISC 1-55 10M

W. A. DUNN

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

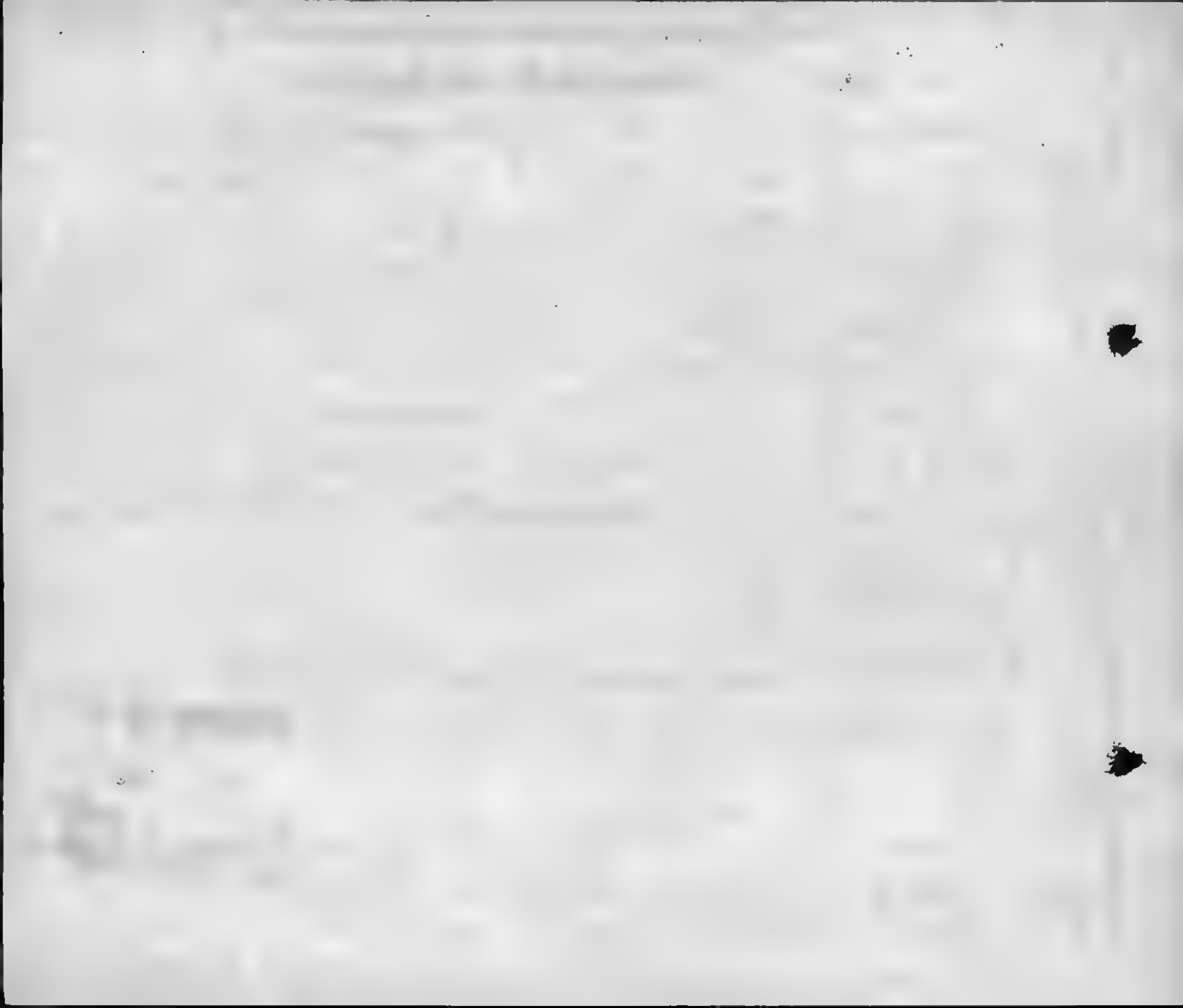
00172

127

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|--|------------------|--|----------------------|---|--------------------------------------|---|------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>aa</u> | | MARYLAND | | STATE <u>md</u> | | COUNTY <u>aa</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Annapolis</u> | | | | TOWN <u>Edgewater</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>a.a. General</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| <u>Wm Stephen</u> (First) <u>Sherbert</u> (Middle) <u></u> (Last) | | | | <u>Jan 28</u> (Month) <u>1956</u> (Year) | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED; (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. | | |
| <u>Male</u> | <u>White</u> | <u>Married</u> | <u>March 29 1905</u> | <u>50</u> yrs | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Lineman</u> | | <u>Gas & Electric</u> | | <u>Edgewater Md</u> | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Wm. H. Sherbert</u> | | | | <u>Lottie Smith</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>212-05-7469</u> | | <u>Inez N. Sherbert, Edgewater Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>anterior Myocardial Infarction</u> | | | | <u>11 d.</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO | | | | | | | |
| STATING UNDERLYING CAUSE LAST, (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia, left lung</u> | | | | <u>11 d.</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>1.17.1956</u> to <u>1.29.1956</u> , that I last saw the deceased alive on <u>1.28.1956</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Frank M. Shipley</u> | | | | ADDRESS (Street, city, town, state) <u>Annapolis Md</u> | | DATE SIGNED <u>1/30/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, of county) | |
| <u>Burial</u> | | <u>Jan 31/56</u> | | <u>Wago Memorial</u> | | <u>Wago Md</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Feb. 2, 1956</u> | | <u>W. J. Carroll</u> | | <u>Benjamin Hardisty</u> | | <u>Galesville Md</u> | |



182

CERTIFICATE OF DEATH

Reg. Dist. No. 20

| | | | | | | | |
|--|------------------|--|----------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN | |
| X TOWN <u>Davidsonville</u> | | | | TOWN <u>Davidsonville</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Deborah Ann Snoogress</u> | | | | <u>January 23 19 56</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Single</u> | <u>Sept. 3, 1955</u> | <u>—</u> yrs. | Months <u>4</u> | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>none</u> | | <u>none</u> | | <u>Rose Hill, Va.</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Mayo Lee Snoogress</u> | | | | <u>Ibonia Lawson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>none</u> | | <u>Mayo Lee Snoogress-Father- same as # 2</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>pneumonia</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>malnutrition</u> | | | | <u>life</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 19. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 21b. PLACE (Home, farm, lecture, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21a. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21i. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 22, 1956</u> to <u>Jan 21, 1956</u> that I last saw the deceased alive on <u>Jan 21, 1956</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Neil H. Simon M.D.</u> | | ADDRESS (Street, city, town, state) <u>95 Cathedral St.</u> | | DATE SIGNED <u>1/23/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | DATE THEREOF <u>Jan. 23, 56</u> | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| | | | | to <u>Rose Hill, Va. (Lee County)</u> | | | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Carrie Smith</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>1-23-56</u> | | | | <u>Hopkins General Home, Baltimore, Md.</u> | | | |

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

U. S. A.

1936



183
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>MARYLAND</u> | | STATE <u>Maryland</u> | | COUNTY <u>Baltimore City</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Crownsville</u> | | LENGTH OF STAY (In this place)
<u>23 yrs. 6 mos. 21 days</u> | | CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore City</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Crownsville State Hospital</u> | | | | STREET ADDRESS (If rural give location)
<u>916 Stricker Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Sadie</u> | | (Middle) <u>Virginia</u> | | (Last) <u>Spriggs</u> | | (Month) <u>1</u> (Day) <u>29</u> (Year) <u>19 56</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH
<u>Unknown</u> | 9. AGE last birthday
<u>71?</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Unk.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>John Spriggs</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Brooks</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
<u> </u> | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT & ADDRESS
<u>Hospital Records</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Coronary heart disease</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u> </u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u> </u> | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis with Mental Deficiency</u> | | | | | | | |
| 19a. DATE OF OPERATION
<u> </u> | | 19b. MAJOR FINDINGS OF OPERATION
<u> </u> | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> </u> M. <u> </u> A. | | 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR?
<u> </u> | | | |
| 22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>55</u> , to <u>1/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/29</u> , 19 <u>56</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>Hildegard H. Reissman</u> | | | | ADDRESS (Street, city, town, state)
<u>Crownsville, Md.</u> | | DATE SIGNED
<u>1/30/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u> </u> | | DATE THEREOF
<u>2/2/56</u> | | NAME OF CEMETERY OR CREMATORY
<u>Arbutus Mem. Park</u> | | LOCATION (City, town, or county) (State)
<u>Baltimore Md</u> | |
| 24. REC'D BY REGISTRAR
<u> </u> | | REGISTRAR'S SIGNATURE
<u>H. M. Joyce</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Chas. H. Cooper</u> | | ADDRESS
<u>Carrollton Ave.</u> | |

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

3 A 174000

DECEMBER 1964

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

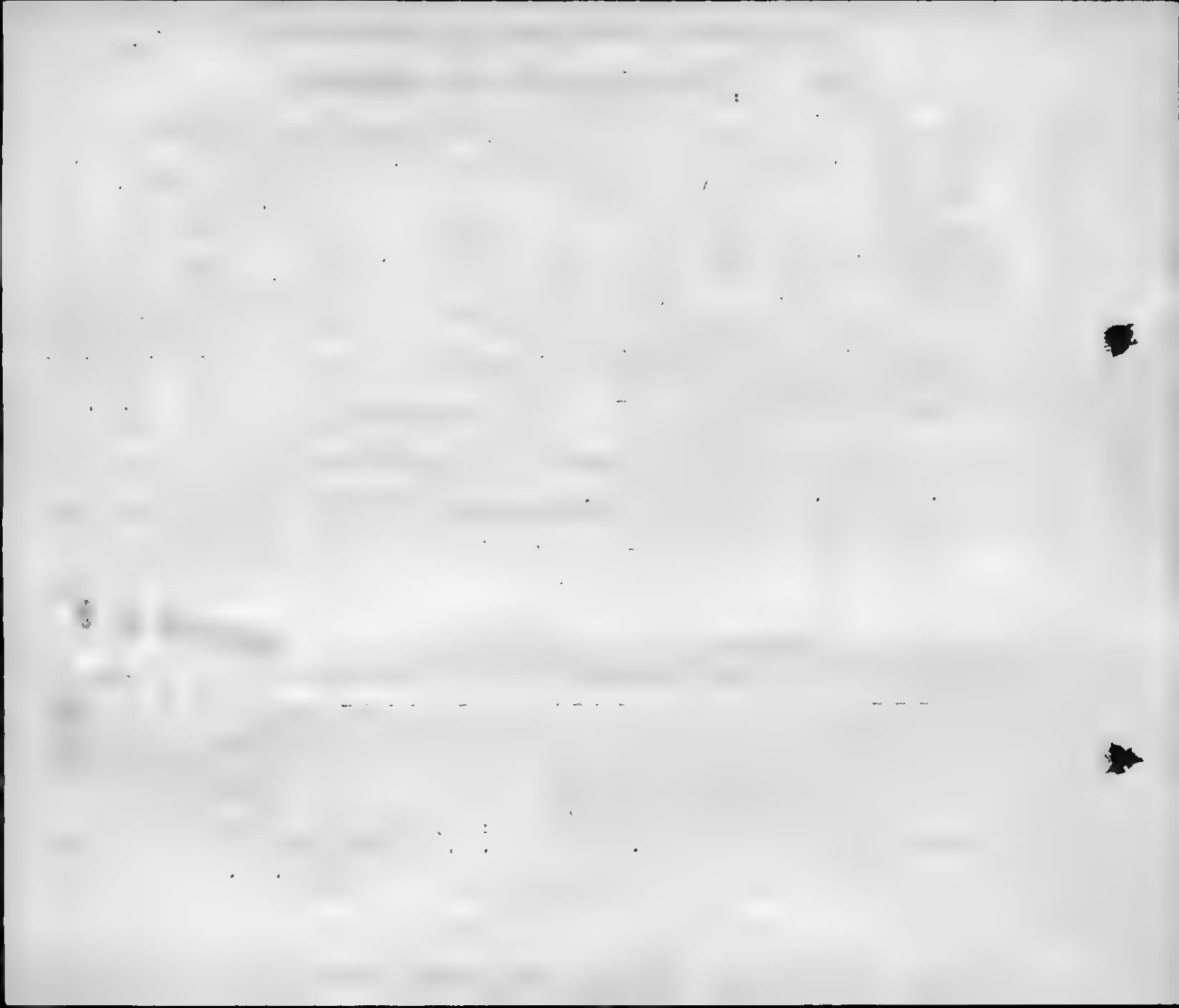
00175

184

CERTIFICATE OF DEATH

Reg. Dist. No. 2422

| | | | | | | | |
|--|-------------------------|---|-------------------------|---|--|---|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>Maryland</u> | | COUNTY <u>Prince George's</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Crownsville</u> | | <u>1 day</u> | | TOWN <u>Upper Marlboro</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>R. D. #2</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Georgia Green Spurlock</u> | | | | <u>1 25 19 56</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | 10. IF UNDER 1 YEAR | | |
| <u>Female</u> | <u>Negro</u> | <u>Widowed</u> | <u>Unknown</u> | <u>82?</u> yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | |
| <u>Unknown</u> | | | | <u>- -</u> | <u>Maryland</u> | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Unknown</u> | | | | <u>Martha Green</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| <u>Unk.</u> | | | | <u>Unk.</u> | | <u>Hospital Records</u> | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility, Hypostatic pneumonia</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>1/24</u>, 19<u>56</u>, to <u>1/25</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1/25</u>, 19<u>56</u>, and that death occurred at <u>4:45 PM</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>L. Benedict, M. D.</u> | | ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u> | | DATE SIGNED <u>1/25/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>1-31-56</u> | | <u>Seaside Cemetery</u> | | <u>Seaside, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Jan 29-1956</u> | | <u>E. J. Collins</u> | | <u>Hoffman Funeral Home</u> | | <u>611-K St N.W.</u> | |



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00176

Item 18 Film G192 2-8-56

185

CERTIFICATE OF DEATH

Reg. Dist. No. 28

| | | | | | | | |
|--|---|---|---|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Baltimore City</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Crownsville</u> | | LENGTH OF STAY (In this place)
<u>5 yrs. 5 mos.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Baltimore City</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Crownsville State Hospital</u> | | | | STREET ADDRESS (If rural give location)
<u>1317 Biddle Street</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last)
<u>Annie Lee Stacey</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>1 18 19 56</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED
<u>Widowed</u> | 8. DATE OF BIRTH
<u>8/1/65?</u> | | 9. AGE last birthday
<u>90?</u> yrs. | IF UNDER 1 YEAR
Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Dressmaking</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>- -</u> | | 11. BIRTHPLACE (State or foreign country)
<u>District of Columbia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>(If Yes, give war or dates of service)</u> | | 16. SOCIAL SECURITY NO.
<u>Unk.</u> | | 17. INFORMANT & ADDRESS
<u>Hospital Records</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| 1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| <u>331x</u> IMMEDIATE CAUSE (A) <u>Asphyxia</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>C. V. A. - Pulmonary embolization</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>(Cerebral vascular accident)</u> | | | | | | | |
| STATING UNDERLYING CAUSE LAST, (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| <u>Questionable carcinomatosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify, that I attended the deceased from <u>8/18</u> ¹⁹⁵⁰ to <u>1/18</u> ¹⁹⁵⁶ that I last saw the deceased <u>alive on</u> <u>1/17</u> ¹⁹⁵⁶ and that death occurred at <u>1:45 AM</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>L. Benedict</u> ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>1/18/56</u> | | | | | | | |
| 23. (BURIAL, CREMATION, REMOVAL) (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| | | <u>1-21-56</u> | | <u>Mt Calvary</u> | | <u>As A. Co. - Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Jan. 20, 1956</u> | | <u>H. M. Jones</u> | | <u>Wm. R. A. Elliott & Ogden</u> | | | |

1941

1

128

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|---|------------------|--|------------------|---|-----------------|----------------------------------|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>D.C.</i> | | MARYLAND | | STATE <i>Md.</i> | | COUNTY <i>29</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <i>Annapolis</i> | | | | TOWN <i>Pasadena</i> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Homewood Convalescent Home</i> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| <i>LEEDS HENLEY STAPLES</i> | | | | <i>1-23-55</i> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <i>Male</i> | <i>White</i> | <i>Married</i> | <i>12-9-1874</i> | <i>81</i> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>Cheerican</i> | | <i>Cheerican</i> | | <i>Maine</i> | | <i>U.S.A.</i> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <i>Nickard Staples</i> | | | | <i>Unknown</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | <i>011-09-9758</i> | | <i>Wilmington L. Staples 809 Bay Ridge</i> | | | |
| 18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 19. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) | | | | <i>uremia</i> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | <i>chronic prostatic hypertrophy -</i> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | <i>myocardial insufficiency -</i> | | | |
| STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>May 1955</i> to <i>Jan 23 1956</i> , that I last saw the deceased alive on <i>Jan 23</i> , 1956, and that death occurred at <i>7 P.</i> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Emily H. Wilson</i> | | | | ADDRESS (Street, city, town, state) <i>Lithuan, Md.</i> | | DATE SIGNED <i>1-24-56</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| <i>Burial</i> | | <i>1-25-56</i> | | <i>Belcrest</i> | | <i>Annapolis</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <i>Jan 24, 1956</i> | | <i>J. J. Trench</i> | | <i>John M. Taylor Sons</i> | | <i>Annapolis Md.</i> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M

RECEIVED

JAN 25 1956

BUREAU W. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

186

CERTIFICATE OF DEATH

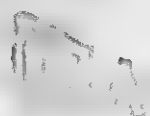
00177

Item 9, FilmG191 1-26-56 et

Reg. Dist. No.

| | | | | | | | |
|---|---|--|---|--|---------------------------------------|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN <u>Harwood</u> | | LENGTH OF STAY
(In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>Harwood</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
- - - - - | | | | STREET ADDRESS
(If rural give location) | | | |
| 3. NAME OF DECEASED
(Type or Print) (First) (Middle) (Last)
<u>ALFRED E STALLINGS</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>JANUARY 17, 19 56</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Widowed</u> | 8. DATE OF BIRTH
<u>October 3, 1877</u> | 9. AGE last birthday
<u>78 79 yrs.</u> | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Rented farm</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Frindship, A.A. Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Amos Stallings</u> | | | | 14. MOTHER'S MARDEN NAME
<u>Susian Phibbons</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)
- - - - - | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT & ADDRESS
<u>Mr Earl Stallings, Son- Same and # 2</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A)
<u>Coronary Occlusion</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B)
<u>Generalized Arteriosclerosis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)
<u>Acute Bacteremia</u> | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)
M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | |
| 21f. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>1-2</u>, 19<u>56</u>, to <u>1-18</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1-18</u>, 19<u>56</u>, and that death occurred at <u>3:20</u> M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>Emily H. Nelson</u> | | | | ADDRESS (Street, city, town, state)
<u>Dutton, Md.</u> | | DATE SIGNED
<u>1-18-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>January 19, 56</u> | | NAME OF CEMETERY OR CREMATORY
<u>Mt Zion Methodist Cemetery</u> | | LOCATION (City, town, or county) (State)
<u>Mt. Zion, Maryland</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE
<u>Elmer Wood Green</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Hopping Funeral Home</u> | | ADDRESS
<u>Annapolis, Md.</u> | |
| DATE
<u>1-19-56</u> | | | | | | | |

U. S.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00179

CERTIFICATE OF DEATH

Reg. Dist. No. 21

129

| | | | | | | | |
|---|--------------------------|--|--------------------------|---|-----------------------------|---|-----------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Anne Arundel | | MARYLAND | | STATE Washington County D. C. | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) 10 TOWN Annapolis | | LENGTH OF STAY (In this place) 1 Month | | CITY (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital | | | | TOWN 3900 Georgia Ave. N. W. 4/12 | | | |
| | | | | STREET ADDRESS 3900 Georgia Ave. N. W. | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) RACHEL STEPHANY | | | | 4. DATE OF DEATH (Month) (Day) (Year) 1/16/1956 19 | | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Unknown | 8. DATE OF BIRTH Unknown | 9. AGE last birthday Approx. 85 yrs Unknown | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (State or foreign country) Unknown | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unknown | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT & ADDRESS Hospital Records | | | |
| 18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 19. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 33/X IMMEDIATE CAUSE (A) Cerebro-vascular Accident | | | | | | | |
| ANTECEDENT CAUSE(S) (B) II Cold Exposure | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. A.M. P.M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 1-15-56 12:05 P.M. to 1-16-56 8:15 A.M., that I last saw the deceased alive on 1-15-56, 1956, and that death occurred at 8:15 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE [Signature] | | | | M.D. C. J. Colquhoun Jr. | | DATE SIGNED 1-16-56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 1/22/1956 | | NAME OF CEMETERY OR CREMATORY Belview Cemetery | | LOCATION (City, town, or county) Virginia (State) | |
| 24. REC'D BY REGISTRAR [Signature] | | REGISTRAR'S SIGNATURE [Signature] | | 25. FUNERAL DIRECTOR'S SIGNATURE Hick's Funeral Home | | ADDRESS Annapolis, Maryland | |
| DATE Jan. 16, 1956 | | | | | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

JAN 12

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00180

130

CERTIFICATE OF DEATH

Reg. Dist. No. 21

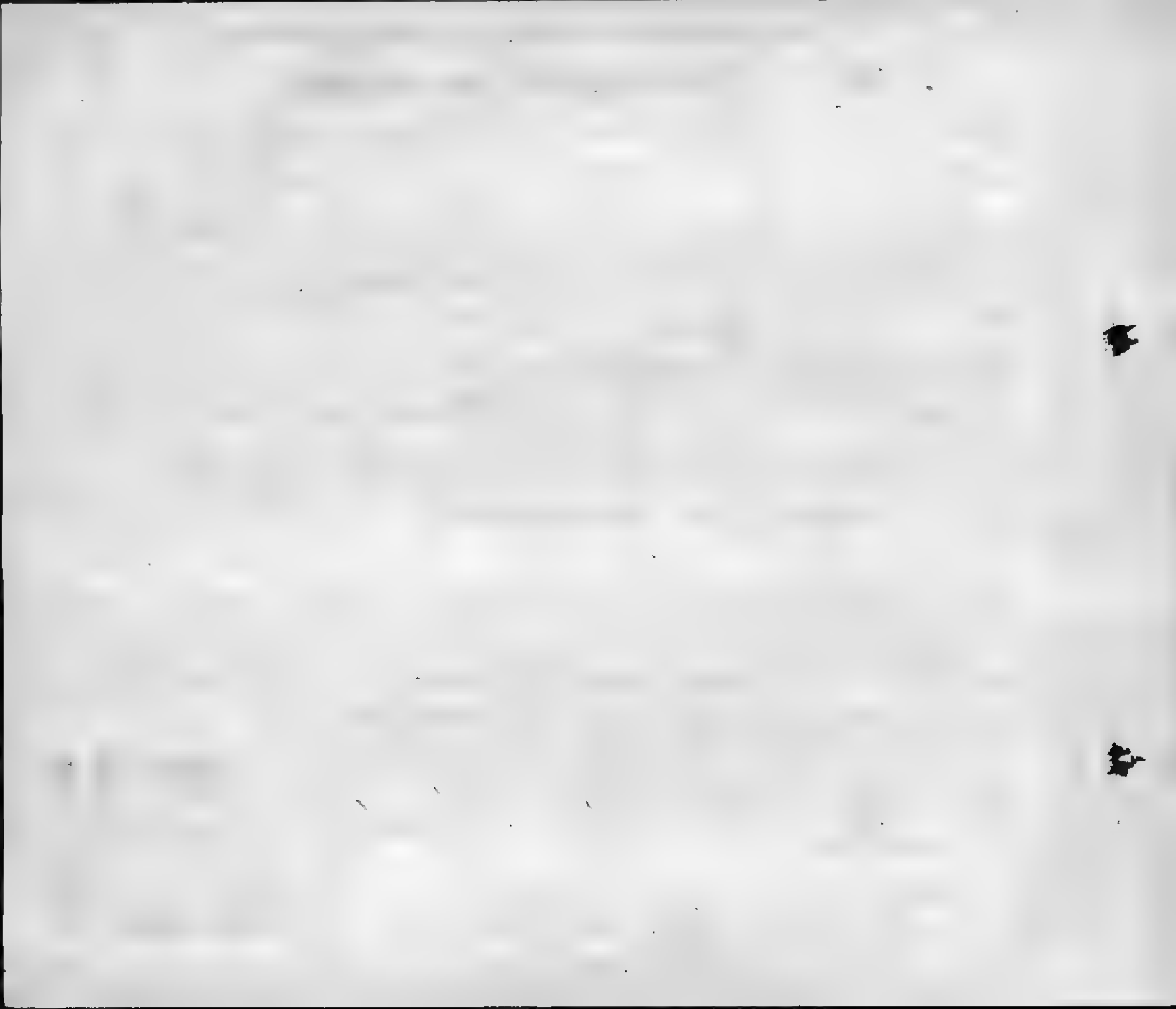
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

| | | | |
|---|---------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <i>St. Anne</i> | MARYLAND | STATE <i>Md</i> | COUNTY <i>A. A.</i> |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <i>Annapolis</i> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <i>Trullberry Hill</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>A. A. Ben. Hospital</i> | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) <i>Theodore A. Johnson</i> | | 4. DATE OF DEATH (Month) <i>1</i> (Day) <i>6</i> (Year) <i>1956</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i> | 8. DATE OF BIRTH <i>July 1 1955</i> |
| 9. AGE last birthday <i>10</i> yrs. | | 10. IF UNDER 1 YEAR (Months) <i>0</i> (Days) <i>0</i> (Hours) <i>0</i> (Min.) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>George A. Stinesburg</i> | | 14. MOTHER'S MARRIEN NAME <i>Evelyn B. Johnson</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS <i>2800 Stinesburg Rd Annapolis</i> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <i>441X</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 day</i> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Bronchial Pneumonia</i> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Pulmonary Edema</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>1/5</i> , 19 <i>56</i> , to <i>1/6</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1/6</i> , 19 <i>56</i> , and that death occurred at <i>10 P</i> M, from the causes and on the date stated above. | | | |
| SIGNATURE <i>Theodore A. Johnson</i> | | DATE SIGNED <i>31 March 1956</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>Jan 12 1956</i> | |
| NAME OF CEMETERY OR CREMATORY <i>St. Anne's</i> | | LOCATION (City, town, or county) <i>at Margate Md</i> | |
| 24. REC'D BY REGISTRAR <i>J. B. Johnson</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i> | |
| DATE <i>Jan 12, 1956</i> | | ADDRESS <i>Annapolis</i> | |



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00181

131

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|---|-------------------------------|--|-------------------------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>AA</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>AA</u> | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Annapolis</u> | | | | TOWN <u>Annapolis Md</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. General Hosp.</u> | | | | STREET ADDRESS (If rural give location) <u>608 Melvin Ave</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) <u>Marion E. Stinecomb</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>1-28-1956</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>July 3-1896</u> | 9. AGE last birthday <u>59</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Fred W. Shaw</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ida E. Saumig</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT & ADDRESS <u>Irvin E. Stinecomb (2)</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetic Coma</u> | | | | <u>1 day</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus</u> | | | | <u>5 yrs.</u> | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive Cardio Vascular Disease</u> | | | | <u>5 yrs.</u> | | | |
| 19a. DATE OF OPERATION <u>1-25-56</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Diabetic gangrene right foot</u> | | 20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. <input type="checkbox"/> P. <input type="checkbox"/>) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan. 1950, to 1-28-1956, that I last saw the deceased alive on 1-28-1956, and that death occurred at 5:00 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>James D. Mark</u> | | M.D. | | ADDRESS (Street, city, town, state) <u>Annapolis Md</u> | | DATE SIGNED <u>1/28/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1-31-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u> | | LOCATION (City, town, or county) (State) <u>Annapolis Md</u> | |
| 24. REC'D BY REGISTRAR <u>J. D. Mark</u> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> | | ADDRESS <u>Annapolis Md</u> | |
| DATE <u>Jan. 30, 1956</u> | | | | | | | |

BUREAU V. S.

FEB 1 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

187

CERTIFICATE OF DEATH

00182

Reg. Dist. No. 23

Inter s... Film G191 1-23-56 et

| | | | | | | | |
|--|------------------------------|--|--|--|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Anne Arundel | | MARYLAND | | STATE Md. | | COUNTY Anne Arundel | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
Linthicum Hgts | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
Linthicum Heights, Md. | | | |
| TOWN | | | | TOWN | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
Andover Road | | | | STREET ADDRESS (If rural give location)
Andover Road | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last)
CATHERINE A. STRAHLMAN | | | | 4. DATE OF DEATH (Month) (Day) (Year)
JANUARY 17 1956 | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH
July 28, 1926 | 9. AGE last birthday
35 36 yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
at home | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Frederick Guy | | | | 14. MOTHER'S MARDEN NAME
Helen Stock | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS
Rudolph Strahlman, husband, above | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) CORONARY THROMBOSIS | | | | INTERVAL BETWEEN ONSET AND DEATH
transmission | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) HYPERTENSIVE CARDIO-VASCULAR DISEASE | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. NONE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan 13, 1956 to Jan 17, 1956 , that I last saw the deceased alive on Jan 13, 1956 , and that death occurred at 6 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Bobby L. Jones M.D. | | | | ADDRESS (Street, city, town, state) 11/17/56 | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | DATE THEREOF
Jan. 21, 1956 | | NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | | LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 24. RECEIVED BY REGISTRAR
Jan. 20, 1956 | | REGISTRAR'S SIGNATURE
Caldwell Madruff | | 25. FUNERAL DIRECTOR'S SIGNATURE
Schimunek Funeral Home, Inc. | | ADDRESS
2601-3-5 E. Madison St. | |

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188

CERTIFICATE OF DEATH

00183

Reg. Dist. No. 20

| | | | | | | | |
|--|------------------|--|-------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>aa</i> | | MARYLAND | | STATE <i>md</i> | | COUNTY <i>aa</i> | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <i>Galleville</i> | | <i>50 yrs</i> | | TOWN <i>Galleville</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE (Month) (Day) (Year) | | | |
| <i>(First) (Middle) (Last)</i>
<i>Elsie Booze Thomas</i> | | | | <i>Jan 21 1956</i> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <i>F</i> | <i>C</i> | <i>Married</i> | <i>Aug 3 1897</i> | <i>58</i> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during, most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>Shucker</i> | | <i>Sea Food</i> | | <i>Sudley MD</i> | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <i>Nathaniel Harris</i> | | | | <i>Mamie Jones</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | <i>213050087</i> | | <i>Melvin Booze Galleville md</i> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| <i>Probable Coronary Occlusion</i> | | | | <i>instantaneous</i> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| <i>"</i> | | | | <i>??</i> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>Jan 20 1956</i> to <i>Jan 21 1956</i> , that I last saw the deceased alive on <i>Jan 20 1956</i> , and that death occurred at <i>6:20 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| <i>J. H. Hendricks</i> | | | | <i>Active Medical Examiner Agency</i> | | <i>1/23/56</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <i>Buried</i> | | <i>Jan 24 1956</i> | | <i>Galleville</i> | | <i>Galleville md</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <i>1/26/56</i> | | <i>Elin M. Williams</i> | | <i>Buried Hendricks</i> | | <i>Galleville md</i> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

U. S. A.

1956



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

132

CERTIFICATE OF DEATH

00184

Reg. Dist. No. 21

| | | | | | | | |
|--|--|--|--|---|--|-------------------------|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>A. A. Co.</i> | | MARYLAND | | STATE <i>Maryland</i> | | COUNTY <i>A. A. Co.</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN | |
| 10 TOWN <i>Annapolis</i> | | | | 10 TOWN <i>Annapolis</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <i>102 Clay Street</i> | | | | <i>102 Clay Street</i> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| <i>Mintie Thomas</i> | | | | <i>1 8 19 56</i> | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH | |
| <i>Female</i> | | <i>Col</i> | | <i>W</i> | | <i>7-5-1885</i> | |
| | | | | | | 9. AGE last birthday | |
| | | | | | | <i>70</i> yrs. | |
| | | | | | | IF UNDER 1 YEAR | |
| | | | | | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| <i>H. W.</i> | | | | <i>Davidsonville, Md</i> | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| <i>Davidsonville, Md</i> | | | | <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <i>Jacob Stewart</i> | | | | <i>Elisa Jones</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| <i>No</i> | | | | <i>101-10-10101</i> | | | |
| 17. INFORMANT & ADDRESS | | | | 18. MEDICAL CERTIFICATION | | | |
| <i>Helen Tongue - Annapolis Md</i> | | | | I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
443X
IMMEDIATE CAUSE (A) <i>Intense pleuritic hypotension</i>
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cardiorenal disease</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>III</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>Dec 8, 1956</i> to <i>Dec 8, 1956</i> , that I last saw the deceased alive on <i>Dec 8, 1956</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Richard E. Smith</i> | | | | DATE SIGNED <i>1/10/56</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | | | 24. REC'D BY REGISTRAR | | | |
| <i>Burial</i> | | | | <i>1-16, 1956</i> | | | |
| DATE THEREOF | | | | REGISTRAR'S SIGNATURE | | | |
| | | | | <i>William Reese, II</i> | | | |
| NAME OF CEMETERY OR CREMATORY | | | | 25. FUNERAL DIRECTOR'S SIGNATURE | | | |
| <i>56 Brewer Hill</i> | | | | <i>William Reese, II</i> | | | |
| LOCATION (City, town, or county) (State) | | | | ADDRESS | | | |
| <i>Annapolis, Md</i> | | | | <i>Annapolis, Md</i> | | | |

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JAN 1 1966

BUREAU V

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22

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate usually should be retained for use as a burial transit permit.

VS A15C 1-51 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00185

189

CERTIFICATE OF DEATH

Reg. Dist. No. 27

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
COUNTY <u>Anne Arundel Co</u> MARYLAND
CITY (If outside corporate limits, write RURAL OR give nearest town)
TOWN <u>St. Geo. J. Meade</u> LENGTH OF STAY (In this place) <u>10 months</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE <u>MD</u> COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>St. Geo J Meade</u>
STREET ADDRESS (If rural give location)
<u>1621B. Forest Ave</u> | |
| 3. NAME OF DECEASED
(Type or Print) (First) (Middle) (Last)
<u>RITA</u> <u>RAMERY-TRISTARI</u> | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>Jan 4 - 56</u> | |
| 5. SEX
<u>F.</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH
<u>June 29-1872</u> |
| 9. AGE last birthday
<u>83</u> yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Porto Rico</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Thomas RAMERY</u> | | 14. MOTHER'S MAIDEN NAME
<u>Anna BERRA</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>→</u> | |
| 17. INFORMANT & ADDRESS
<u>Wm Wm L. Briggs</u> | | | |
| 18. MEDICAL CERTIFICATION
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
IMMEDIATE CAUSE (A) <u>Acute Cerebral Infarct</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular Disease</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 hours</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)
M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21e. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Jan 10-55</u> to <u>Jan 4-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 4-56</u> , 19 <u>56</u> , and that death occurred at <u>4A</u> M. from the causes and on the date stated above.
SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>Blanton Md</u> DATE SIGNED <u>1-4-56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24. REC'D BY REGISTRAR
DATE <u>1/7/55</u> REGISTRAR'S SIGNATURE <u>[Signature]</u> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE
<u>[Signature]</u> | | 26. ADDRESS
<u>1217 Rd Paul St</u> | |

BUREAU V. S.

JAN 5 1971

RECEIVED

190

CERTIFICATE OF DEATH

Reg. Dist. No. 28

| | | | | | | | |
|---|------------------|--|---------------------|---|-----------------|--|-------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Washington D.C.</u> | | COUNTY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN | |
| TOWN <u>Millersville Md</u> | | <u>9 months</u> | | TOWN <u>Washington D. C.</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sanns Nursing Home</u> | | | | STREET ADDRESS (If rural give location) <u>16 th St. N.W.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | 19 | |
| (First) <u>Mary</u> (Middle) <u>Underwood</u> (Last) | | | | (Month) <u>Jan</u> (Day) <u>31</u> (Year) <u>1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS | |
| <u>female</u> | <u>white</u> | <u>single</u> | <u>Mar 15, 1888</u> | <u>67</u> yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Teacher retired</u> | | <u>Music</u> | | <u>Newton Grove N. C.</u> | | <u>U S A</u> | |
| 13. FATHER'S NAME <u>Thomas W Underwood</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Monk</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | | | <u>Bernard Underwood Riva Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u> | | | | <u>1 year</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 23</u> , 19 <u>56</u> , to <u>Jan 31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>56</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Edward G. Menotti</u> | | | | ADDRESS (Street, city, town, state) <u>Millersville Md</u> | | DATE SIGNED <u>1-31-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Feb 2, 1956</u> | | <u>Fort Lincoln Cemetery</u> | | <u>Colmar Manor Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Feb 2 1956</u> | | <u>L. M. Joyas</u> | | <u>F. Gasch's Sons</u> | | <u>Hyattsville Md.</u> | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

521

10/1

191

CERTIFICATE OF DEATH

Reg. Dist. No. 22

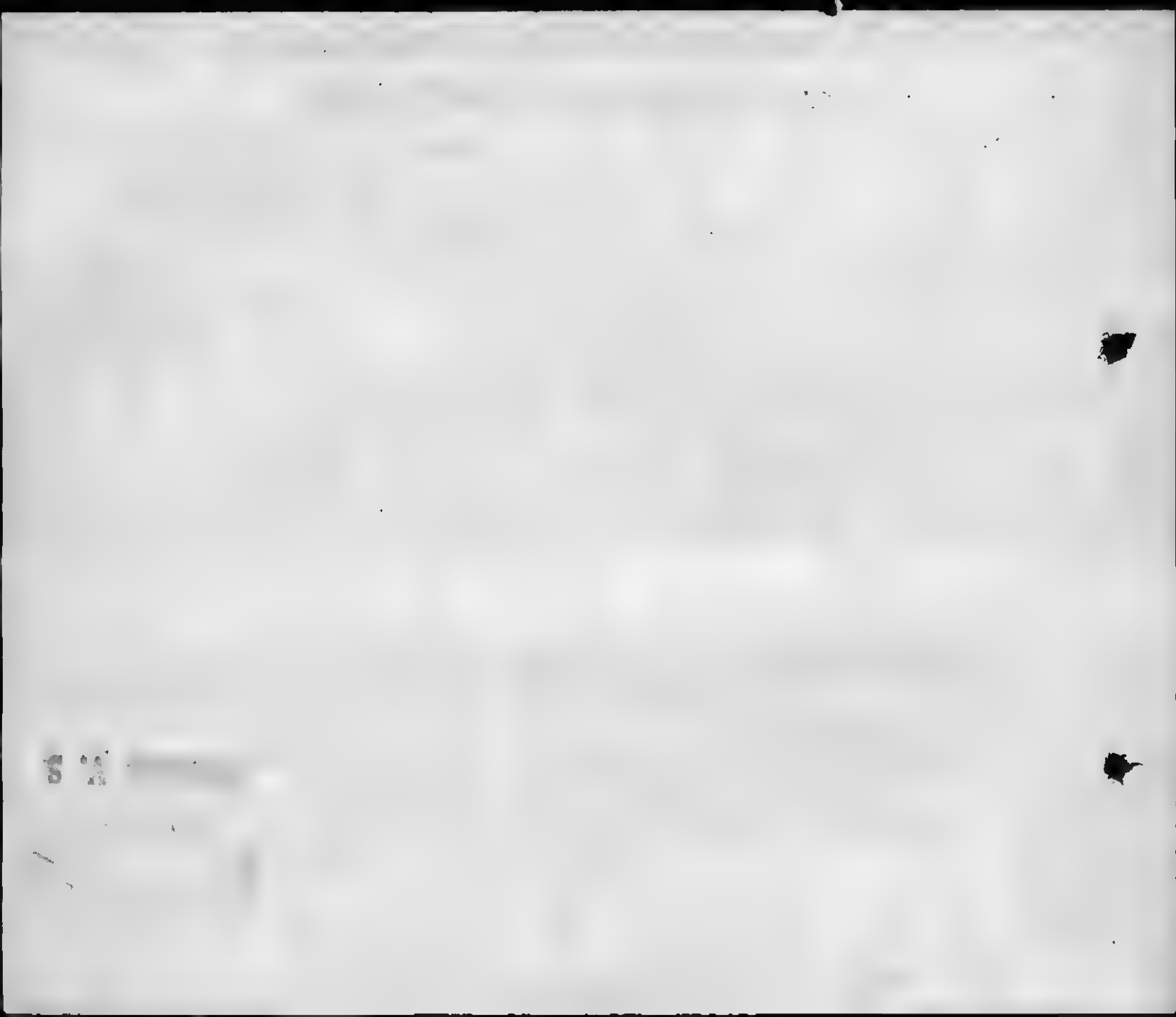
| | | | | | | | |
|---|------------------|--|---------------------|---|-----------------|----------------------------------|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Anne Arundel</i> | | MARYLAND | | STATE <i>Maryland</i> | | COUNTY <i>Anne Arundel</i> | |
| CITY OR TOWN <i>Screens</i> | | LENGTH OF STAY (in this place) | | CITY OR TOWN <i>Screens</i> | | (if rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <i>Harry</i> (Middle) <i>Ernest</i> (Last) <i>Wagner</i> | | | | (Month) <i>Jan.</i> (Day) <i>21</i> (Year) <i>1956</i> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <i>Male</i> | <i>White</i> | <i>Widowed</i> | <i>Mar 29, 1882</i> | <i>73</i> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>Farmer</i> | | <i>Farming</i> | | <i>Germany</i> | | <i>U.S.A.</i> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <i>John August Wagner</i> | | | | <i>Anna Louise Bussey</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <i>No</i> | | <i>None</i> | | <i>Harold E. Wagner - Screens Md.</i> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 15. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) | | | | <i>Cardio-Vascular Disease</i> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | | <i>Diabetes</i> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | <i>3 years</i> | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| <i>None</i> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work Not while at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | M. <input type="checkbox"/> <input type="checkbox"/> | | | | | |
| 22. I hereby certify that I attended the deceased from <i>Jan 23</i> , 19 <i>56</i> , to <i>Jan 25</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Jan 23</i> , 19 <i>56</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>James S. Bellinger</i> | | | | ADDRESS (Street, city, town, state) <i>108 Central Ave. Glen Burnie</i> | | DATE SIGNED <i>Jan 25, 1956</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| <i>Burial</i> | | <i>1/28/56</i> | | <i>FRIENDSHIP CEMT.</i> | | <i>ANNE ARUNDEL Co. MD</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <i>Jan 26, 1956</i> | | <i>Clara Kachup</i> | | <i>C. F. Hoffmann</i> | | <i>3218 Hudson St.</i> | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



192

CERTIFICATE OF DEATH

Reg. Dist. No. 242

| | | | | | | | |
|---|-----------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Anne Arundel | | STATE Maryland | | COUNTY Prince George's | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN Crownsville | | 2 days | | TOWN Upper Marlboro | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital | | | | STREET ADDRESS (If rural give location) R. D. #2 | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| George Washington | | | | 1 26 19 56 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Male | Negro | Married | Unknown | 76? | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Laborer | | Unknown | | Maryland | | U. S. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| George Washington | | | | Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| Unk. | | Unk. | | Hospital Records | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 4221 IMMEDIATE CAUSE (A) Anoxemia secondary to pulmonary edema | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Pneumonia, ACVD | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) R.O. Carcinomatosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from 1/24, 19 56, to 1/26, 19 56, that I last saw the deceased alive on 1/26, 19 56, and that death occurred at 7:45 a.m. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE (L. Benedict, M. D.) | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| M.D. | | | | Crownsville, Md. | | 1/26/56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | | (State) | |
| Burial | 1-31-56 | Lincoln Memorial | | Luthan Md. | | | |
| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | | |
| DATE Jan 29-1956 | Edna L. Collins | Harris Funeral Service | | 611 K St. N.W. | | | |

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



201 1000-0000

81

133

CERTIFICATE OF DEATH

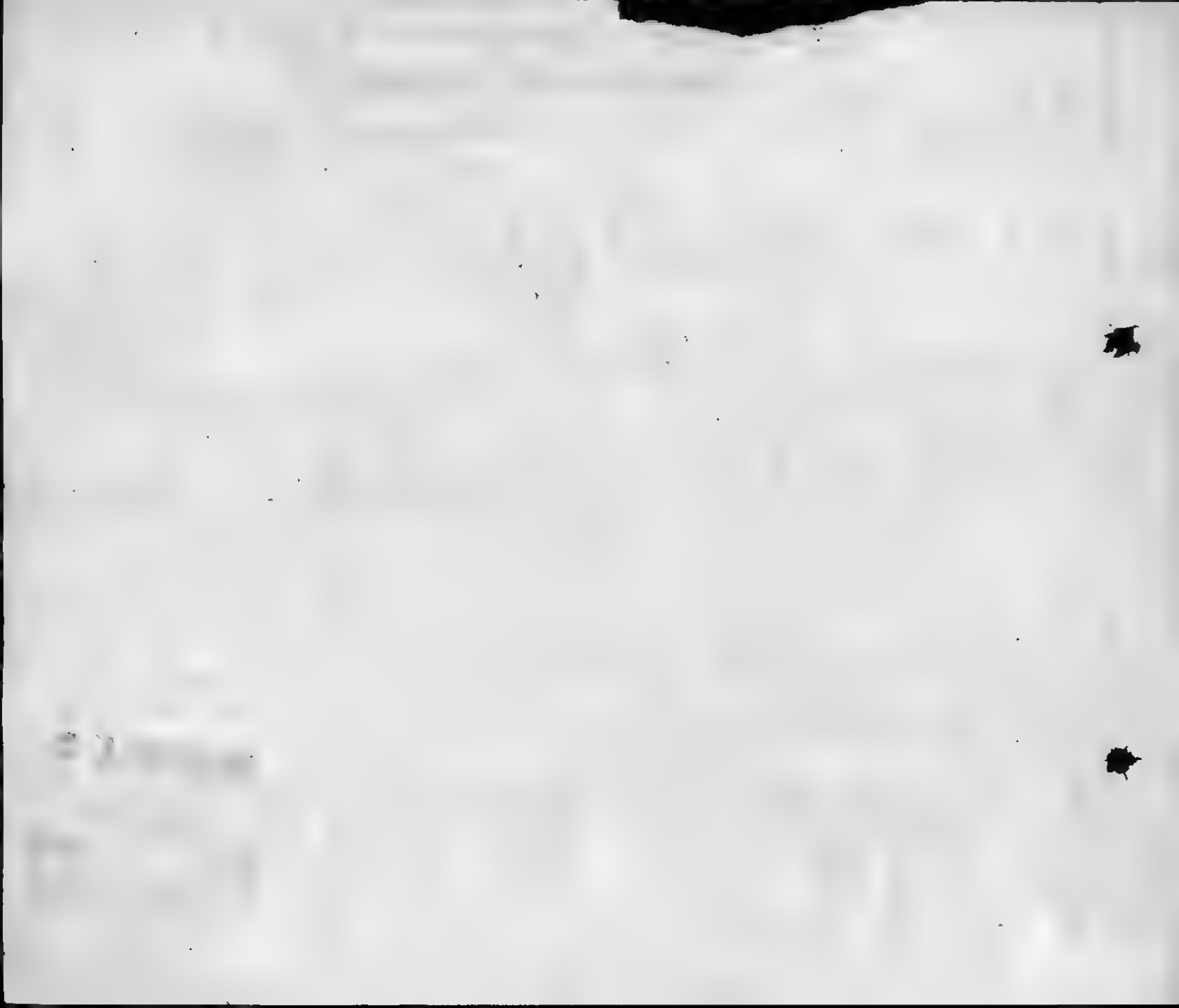
Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>A.A. Co.</i> | | MARYLAND | | STATE <i>Maryland</i> | | COUNTY <i>A.A. Co.</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <i>Annapolis</i> | | <i>Life</i> | | TOWN <i>Annapolis</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>A.A. General Hosp.</i> | | | | STREET ADDRESS (If rural give location) <i>5 Greenfield St.</i> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| <i>Roberta Washington</i> | | | | <i>1 31 19 56</i> | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>Col.</i> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i> | | 8. DATE OF BIRTH <i>10-18-54</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE last birthday <i>1</i> yrs. <i>13</i> mos. <i>13</i> days | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md U.S.A.</i> | |
| 13. FATHER'S NAME <i>Robert Washington</i> | | | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service) | | | | 14. MOTHER'S MAIDEN NAME <i>Dorothy Martin</i> | | 16. SOCIAL SECURITY NO. <i>1-31-56-19</i> | |
| 17. INFORMANT & ADDRESS <i>Robert H Washington - Annapolis</i> | | | | 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (A) <i>Pneumonia</i> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>1-31-56</i> , 19 <i>56</i> , to <i>1-31-56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1-31-56</i> , 19 <i>56</i> , and that death occurred at <i>3-12</i> M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>H. T. Allen</i> | | DATE SIGNED <i>2-1-56</i> | | ADDRESS (Street, city, town, state) <i>62 E. ... St</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>2-3-56</i> | | NAME OF CEMETERY OR CREMATORY <i>Chews Chapel</i> | | LOCATION (City, town, or county) (State) <i>Owensville, Md</i> | |
| 24. REC'D BY REGISTRAR <i>Feb. 6, 1956</i> | | REGISTRAR'S SIGNATURE <i>Jim J. French</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr.</i> | | ADDRESS <i>108 W. Wash. St. Annapolis, Md.</i> | |



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00190

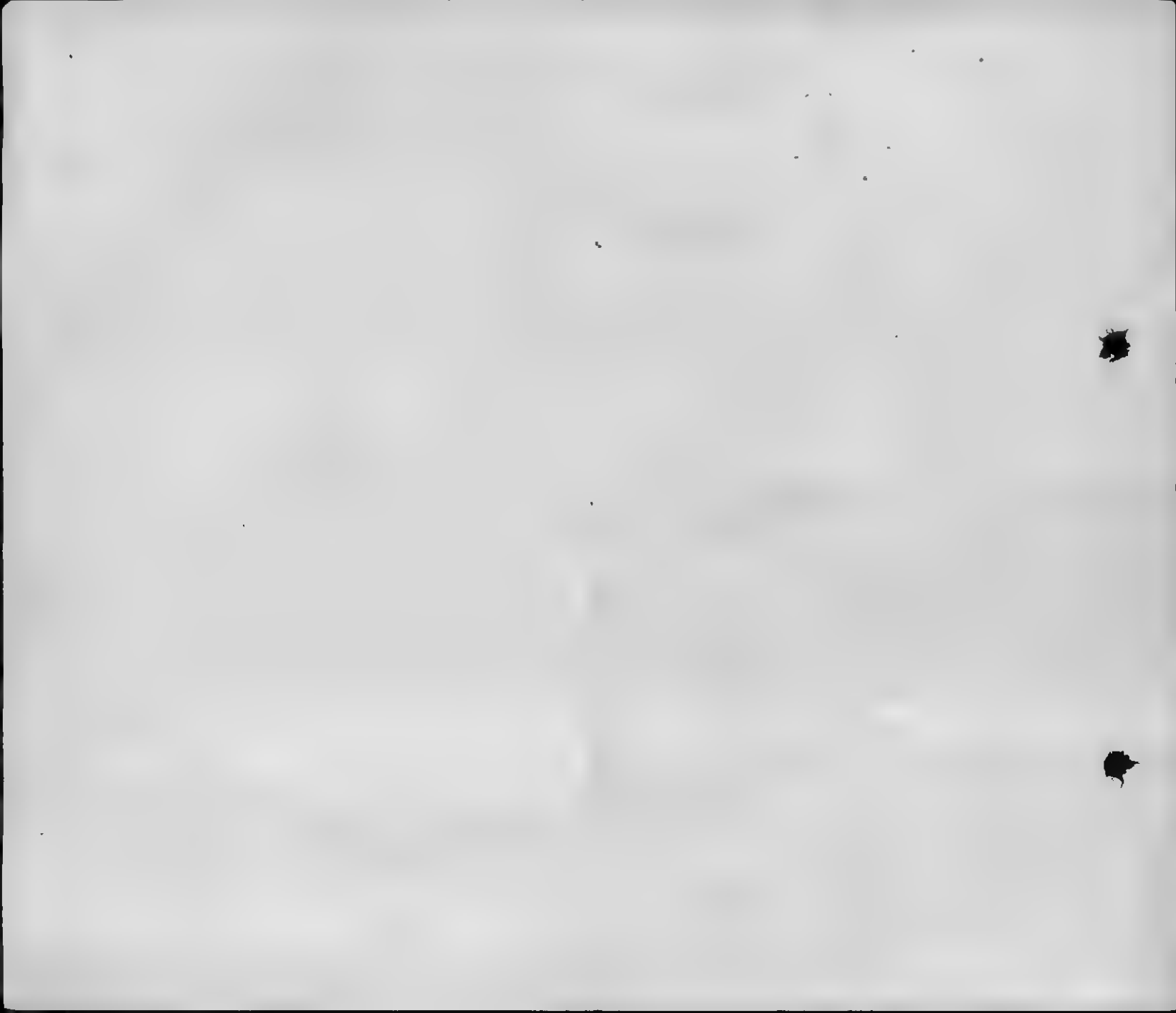
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>A.A.</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | OR TOWN | |
| <input checked="" type="checkbox"/> TOWN <u>Sunset Beach</u> | | <u>6 months</u> | | TOWN <u>Same</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montrose and Bedford Rds.</u> | | | | STREET ADDRESS (If rural, give location) <u>Same</u> | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE OF DEATH | | | |
| (First) <u>John</u> | | (Middle) | | (Last) <u>Wenerski</u> | | (Month) (Day) (Year) <u>January 22rd 19 56</u> | |
| (Type or Print) | | | | | | | |
| 5. SEX: <u>M</u> | | 6. COLOR OR RACE: <u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | | 8. DATE OF BIRTH: <u>12/25/93</u> | |
| | | | | | | 9. AGE last birthday: <u>62</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Enamaler</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>American Radiator</u> | | 11. BIRTHPLACE (State or foreign country): <u>Poland, Europe.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Michael Wenerski</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Theodora Kolankiewicz</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: <u>213-01-4529</u> | | 17. INFORMANT & ADDRESS: <u>Frances Wenerski (Wife)</u> | | | |

| | | | | | |
|---|--|--|--|--|--|
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | |
| Immediate cause (a) <u>Coronary Occlusion</u> | | | | Sudden | |
| DUE TO | | | | | |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | | | | | |
| (c) | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| SIGNATURE <u>Michael X. Paerbo</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/22/56</u>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF: <u>1/25/56</u> | | NAME OF CEMETERY OR CREMATORY: <u>Ellen Haven</u> | |
| LOCATION (City, town, or county) (State): <u>A. A. Co. Md.</u> | | 24. FUNERAL DIRECTOR: <u>Wm. S. Fialkowski</u> | | ADDRESS: <u>2007 Eastern Ave</u> | |
| DATE REC'D BY LOCAL REG. <u>1-25-56</u> | | REGISTRAR'S SIGNATURE: <u>[Signature]</u> | | | |



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00191

194

CERTIFICATE OF DEATH

Reg. Dist. No. *8*

| | | | | | | | |
|---|-------------------------------|--|-----------------------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>A.A.</i> | | MARYLAND | | STATE <i>-MD</i> | | COUNTY <i>AA</i> | |
| CITY OR TOWN <i>MILLERSVILLE</i> | | LENGTH OF STAY (in this place) | | CITY OR TOWN <i>CAPE ST JOHN</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>SANNS NURSING HOME</i> | | | | STREET ADDRESS <i>RT 1 ANNAPOLIS</i> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| <i>LAFOREST WESTON</i> | | | | <i>1-17-1956</i> | | | |
| 5. SEX <i>MALE</i> | 6. COLOR OR RACE <i>WHITE</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>WIDOW</i> | 8. DATE OF BIRTH <i>6-11-1873</i> | 9. AGE last birthday <i>82</i> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SHOEMAKER</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>LEATHER</i> | | 11. BIRTHPLACE (State or foreign country) <i>MAINE</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>ALEXANDER WESTON</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. (If Yes, give year or dates of service) | | 17. INFORMANT & ADDRESS <i>Irving L. WESTON</i> | | (2) | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <i>arterio-sclerotic Heart Disease</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>Aug</i> , 19 <i>56</i> , to <i>Jan 17</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Jan 16</i> , 19 <i>56</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Edmund J. G. (Mentel)</i> | | M.D. | | ADDRESS (Street, city, town, state) <i>Cambridge Md</i> | | DATE SIGNED <i>1-17-56</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>REMOVAL</i> | | DATE THEREOF <i>1-18-56</i> | | NAME OF CEMETERY OR CREMATORY <i>Pine Grove</i> | | LOCATION (City, town, or county) (State) <i>Lynn Mass</i> | |
| 24. REC'D BY REGISTRAR <i>1-18-56</i> | | REGISTRAR'S SIGNATURE <i>J. M. J.</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor</i> | | ADDRESS <i>Annapolis Md</i> | |

INSTRUCTIONS

THEATRE OF THE DEAD The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 12 hours after death. After this certificate has been executed by the attending physician and properly filled in by the funeral director, the third copy of this death certificate assembly should be detailed for use as a burial transit permit.

VS AISC 1-55 10M

W. A. SIVTSEV

134

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00192
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 21

| | | | |
|---|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY Anne Arundel | MARYLAND | STATE Md. | COUNTY Anne Arundel |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN Annapolis | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town)
TOWN Annapolis | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural, give location)
RFD #3, Annapolis Neck Rd. | |
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH | |
| (First) Harriett | (Middle) Jones | (Last) Williams | (Month) 1 (Day) 2 (Year) 19 56 |
| 5. SEX: Female | 6. COLOR OR RACE: Colored | 7. SINGLE, MARRIED, WIDOWED, OR FORCED (Specify): M | 8. DATE OF BIRTH: July 7, 1908 |
| 9. AGE last birthday: 47 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country): Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME: Simon Jones | | 14. MOTHER'S MAIDEN NAME: Marietta Covington | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unk.) (If Yes, give war or dates of service) No | | 16. SOCIAL SECURITY No.: | |
| 17. INFORMANT & ADDRESS: William Williams - Annapolis, Md. | | | |

| | | | |
|---|--|---|--|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | |
| Immediate cause (a)..... 4/4 X Aortic Stenosis and Insufficiency
DUE TO Rheumatic Valvulitis.
Antecedent cause(s) (b).....
Diseases or conditions, if any, giving rise to the above cause DUE TO
stating underlying cause last (c) | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | |
| 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| SIGNATURE: [Signature] | | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> DATE SIGNED 1/6/56 | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 1-9-56 | NAME OF CEMETERY OR CREMATORY: Brewer Hill | |
| LOCATION (City, town, or county) (State): Annapolis, Md. | 24. FUNERAL DIRECTOR: William Beu, Jr. | ADDRESS: Annapolis, Md. | |
| DATE REC'D BY LOCAL REG. Jan 9, 1956 | REGISTRAR'S SIGNATURE: [Signature] | | |

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00193

Reg. Dist.

No. 114

| | | | | | | | |
|--|-------------------------|---|----------------------------|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY Anne Arundel | | MARYLAND | | STATE Maryland | | COUNTY Dorchester | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits write RURAL and give nearest town)
TOWN Cambridge | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS in Ambulance | | | | STREET ADDRESS (If rural, give location)
27 High Street | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last)
(Type or Print) FRANK A. WOOSTER | | 4. DATE OF DEATH Jan 16 1956 | | 5. AGE last birthday: 77 yrs. | | 6. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: 2-7-1978 | 9. BIRTHPLACE (State or foreign country): Troy, Penn. | | 10. CITIZEN OF WHAT COUNTRY: U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Reporter | | 10b. KIND OF BUSINESS OR INDUSTRY: Newspapers | | 11. BIRTHPLACE (State or foreign country): Troy, Penn. | | 12. CITIZEN OF WHAT COUNTRY: U.S.A. | |
| 13. FATHER'S NAME: Not Known | | | | 14. MOTHER'S MAIDEN NAME: Not Known | | | |
| 15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes | | 16. SOCIAL SECURITY No.: Sp. Am. War | | 17. INFORMANT & ADDRESS: Mrs. Marjorie Buchard Wooster Cambridge, Md. | | | |

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| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a)
DUE TO

Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)
DUE TO | | | | | |
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..... | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH | | | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .
SIGNATURE <i>John M. Moore</i> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Jan. 17 1956
M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): Burial | | DATE THEREOF Jan. 13, 1956 | | NAME OF CEMETERY OR CREMATORY Dor. Mem. Park | | LOCATION (City, town, or county) (State) Cambridge Dorchester Md. | |
| DATE REC'D BY LOCAL REG. Jan. 17, 1956 | | REGISTRAR'S SIGNATURE <i>John M. Moore</i> | | 24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service Cambridge, Md. | | | |



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00194

196

CERTIFICATE OF DEATH

Reg. Dist. No. 27

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|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>MARYLAND</u> | | STATE <u>Tennessee</u> | | COUNTY <u>Williamson</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Fort George G. Meade</u> | | <u>5 months</u> | | TOWN <u>Nolenville</u> | | <u>79K-3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>Route #1</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) | | | | 4. DATE OF DEATH | | | |
| <u>JAMES EARL YATES</u> | | | | <u>January 24 19 56</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 8. DATE OF BIRTH <u>January 23, 1956</u> | | 9. AGE last birthday <u>19</u> yrs. | |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | | | | | | IF UNDER 1 YEAR
Months Days
<u>19</u> <u>44</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Thomas Allen Yates</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Patricia Edine Clark</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Father: Severn, Maryland</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>762.5 Atelectasis Atelectasis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>19 hrs 44 min</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity Prematurity</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan 23, 1956, to Jan 24, 1956, that I last saw the deceased alive on Jan 24, 1956, and that death occurred at 12:04 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>HERBERT L. NEEDLEMAN</u> Ist Lt, Mc. | | | | ADDRESS (Street, city, town, state) <u>Ft GG Meade, Md.</u> DATE SIGNED <u>24 Jan 56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>25 Jan 56</u> | | NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Ft GG Meade, Md.</u> | |
| 24. RECEIVED BY REGISTRAR <u>W. L. Saylor</u> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Chaplain Quigley, Ft Meade, Md.</u> | | ADDRESS | |
| DATE <u>24 Jan 56</u> | | <u>W. L. Saylor, 1st Lt MSC</u> | | | | | |

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CERTIFICATE OF DEATH

128

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

CAUSE OF DEATH

DATE

TIME

PLACE

NAME OF PHYSICIAN

NAME OF HOSPITAL

NAME OF NURSE

DATE

NAME OF DECEASED

NAME OF DECEASED

BUREAU V. S.

JAN 26 1956

RECEIVED

INSTRUCTIONS

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00195

135

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>AA</u> | MARYLAND | STATE <u>MD</u> | COUNTY <u>AA</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>ANNAPOLIS</u> | LENGTH OF STAY
(In this place) | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>ANNAPOLIS</u> | |
| HOSPITAL OR
INSTITUTION OR
STREET ADDRESS
<u>AA GENERAL</u> | | STREET
ADDRESS
<u>135 GLOUCESTER ST</u> | |
| 3. NAME OF DECEASED
(Type or Print) | | 4. DATE OF DEATH | |
| <u>MARGARET G ZELLER</u> | | <u>1-13-1956</u> | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH |
| <u>FEMALE</u> | <u>WHITE</u> | <u>WIDOW</u> | <u>Unknown</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) |
| <u>House wife</u> | | <u>HOME</u> | <u>ANNAPOLIS MD</u> |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| <u>THOMAS FARRELL</u> | | <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S ADDRESS |
| | | <u>-</u> | <u>Joseph P. Farrell 121 Cathedral St Annapolis, Md</u> |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 d.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>-</u> | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>-</u> | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>-</u> | | |
| 22. I hereby certify that I attended the deceased from <u>1/10/56</u> , 19 <u>56</u> , to <u>1/13/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/12/56</u> , 19 <u>56</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above. | | | |
| SIGNATURE <u>Frank M. Shipley</u> | | DATE SIGNED <u>1/14/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 24. REC'D BY REGISTRAR <u>John M. Saylor</u> | |
| DATE <u>Jan. 16, 1956</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u> | |

00195

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

182

BUREAU V. R.

JAN 17 1956

RECEIVED

INSTRUCTIONS
This certificate should be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be completed as soon as possible after death, and before the body is buried or cremated. It should be signed by the physician or other qualified person, and then filed with the local health officer. A copy of this certificate should be sent to the State Department of Health, Boston, Massachusetts.